Jurisdictional Statement

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No. 81-185

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

CHRIS SIMOPOULOS, M.D., FACOG, *Appellant,*

v.

COMMONWEALTH OF VIRGINIA, *Appellee.*

On Appeal From The Supreme Court Of Virginia

JURISDICTIONAL STATEMENT

ROY LUCAS
Counsel of Record

ROY LUCAS & ASSOCIATES, P.C.
Suite 424
1055 Thomas Jefferson St., N.W.
Washington, D.C. 20007
(202) 338-6955

Attorneys for Appellant

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QUESTIONS PRESENTED

I. Whether the Virginia abortion law was unconstitutionally applied to convict Dr. Chris Simopoulos, in violation of the principles in *United States* v. *Vuitch* and the Due Process Clause, where the *burden of proof* was placed totally upon him to establish the statutory exception of medical necessity for the abortion?

II. Whether the conviction must be reversed as violative of the Due Process clause where the prosecution presented *no evidence* that any act of Dr. Simopoulos in fact *caused* the demise or expulsion of the fetus?

III. Whether the *mandatory hospitalization* requirement of the Virginia abortion law abridges the rights of privacy and due process by unduly restricting access to second trimester abortions and delegating to hospitals the authority to ban such abortions altogether?

IV. Whether, as applied in this case, the mandatory hospital rule violates due process where the patient was a mature minor in jeopardy of parental retribution, and the only available hospital required parental consent from all minors seeking second trimester abortions?

PARTIES BELOW

The only parties in the Supreme Court of Virginia were Chris Simopoulos, M.D., and the Commonwealth.

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On Appeal From The Supreme Court Of Virginia

JURISDICTIONAL STATEMENT

OPINIONS BELOW

The April 24, 1981, decision of the Supreme Court of Virginia is reported as *Commonwealth* v. *Simopoulos,* 277 S.E.2d 194 (Va. 1981). The text is set out in Appendix A, *infra,* at 1a-22a.

The April 16, 1980, judgment of conviction by the Circuit Court of Fairfax County, Virginia, is not officially reported. The text of the judgment and sentencing are set out verbatim in Appendix B, *infra,* at 23a-26a.

JURISDICTION

(i) Nature Of The Proceeding

This case involves a felony prosecution of a board certified obstetrician gynecologist on charges of violating a restriction in the Virginia abortion law, Va. Code 18.2-71. There was a bench trial, conviction, and affirmance by the Supreme Court of Virginia. Dr. Simopoulos served twenty days in the Fairfax adult detention center and was unconditionally released July 6, 1981, on inactive probation. The defense asserted the unconstitutionality of the statute throughout all proceedings, and preserved all the federal questions for review on appeal here.

(ii) Judgment Below

The Supreme Court of Virginia entered the judgment appealed from on April 24, 1981. (App. A at la). Dr. Simopoulos did not seek a rehearing.

A notice of appeal to this Court was filed in the Supreme Court of Virginia on July 6, 1981. (App. F). The Chief Justice extended the time for docketing this appeal to September 3, 1981.

(iii) Jurisdiction In This Court

Section 1257(2), (3), Title 28, U.S. Code vests jurisdiction in this Court because the final judgment below upheld a state statute and its application against federal claims of unconstitutionality.

Cases which support jurisdiction over the appeal include *Griswold* v. *Connecticut,* 381 U.S. 479 (1965); *Loving* v. *Commonwealth,* 388 U.S. 1 (1967); *Bigelow* v. *Commonwealth,* 421 U.S. 809 (1975); *Moore* v. *City of East Cleveland,* 431 U.S. 494 (1977); *H.L.* v. *Matheson,* 450 U.S. _____ (1981); *Schad* v. *Borough of Mt. Ephraim,* 452 U.S. _____ (1981).

STATUTE INVOLVED

The only Virginia abortion statute under which Dr. Simopoulos was convicted is Va. Code 18.2-71. The entire statutory scheme is set out in note 2 of the Virginia Supreme Court opinion. (App. A at 4a-6a, 277 S.E.2d at 197-98). The principal section provides:

> "*Sec. 18.2-71.* Producing abortion or miscarriage, etc.; penalty. — *Except as provided in other sections* of this article, *if any person* administer to, or cause to be taken by a woman, any drug or other thing, or *use means,* with intent to destroy her unborn child, or *to produce abortion* or miscarriage *and thereby* destroy such child, or *produce such abortion* or miscarriage, he shall be guilty of a Class 4 *felony.* (Code 1950, Sec. 18.1-62; 1960, c. 358; 1970, c. 508; 1975, cc. 14, 15.)" (Emphasis added).

INDICTMENT

The indictment reads as follows:

> "The Grand Jurors of the Commonwealth of Virginia, in and for the body of the County of Fairfax, and now attending the said Court at its January Term, 1980 charges that: On or about the 10th day of November, 1979 in the City of Falls Church, Chris Simopoulos did unlawfully and feloniously, *during the second trimester* of a pregnancy and *outside a hospital* licensed by the State Department of Health or under the control of the State Board of

Mental Health and Mental Retardation, use means upon a white female, aged 17, with the intent to produce abortion and thereby destroy her unborn child. VA. CODE 18.2-71." (Emphasis added).

The indictment alleges the exceptions as to length of pregnancy (second trimester) and location outside of a hospital. Va. Code 18.2-72, 18.2-73. However, it does not negate the exception in Va. Code 18.2-74.1 (medical necessity).

STATEMENT OF THE CASE

Facts

Chris Simopoulos, M.D., was practicing obstetrics and gynecology in northern Virginia during the fall of 1979. He had grown up in the rural mountains of Macedonia, Greece, and graduated from medical school at the University of Athens. He completed his residency in the United States, became certified by the American Board of Obstetrics and Gynecology, became a Fellow of the American College of Obstetricians and Gynecologists, and settled in northern Virginia with his wife and four young sons. His practice in Virginia covered the full range of ob/gyn treatment, including abortions. (Tr., Testimony of Chris Simopoulos, M.D., April 16, 1980).

Patricia McDonald, a high school student in Woodbridge, Virginia, became pregnant out-of-wedlock in the fall of 1979. (Va. App. at 177a).[1] She had not been using any form of contraception. She decided to have an abortion. (Va. App. at 316a). She did not want her parents to know (Va. App. at 180a, 319a) because she was terrified of the consequences. (Va. App. at

[1] Va. App. refers to the Appendix in the Virginia Supreme Court.

443a-444a). She did nothing about the pregnancy for 16 weeks. (Va. App. at 179a).

The uncontradicted evidence showed that only two of the seventeen hospitals in Northern Virginia permit second trimester abortions. (Va. App. at 82a, 112a). Both of those hospitals then required parental consent. (Va. App. at 82a, 112a, 388a). Dr. Simopoulos had privileges at Fairfax Hospital, one of those institutions. He could not, however, admit Patricia McDonald to the hospital as an inpatient without her parents finding out.

In addition to the dual obstructions of parental consent and limited hospital availability, Patricia McDonald also faced the obstacle of cost. A state-imposed hospital requirement for abortion has the direct consequence of almost tripling the total cost of the abortion. This factor increased the difficulty for her. (Va. App. at 184a).

Patricia McDonald went with her boyfriend[2] to the clinic of Dr. Chris Simopoulos in Falls Church, Virginia. Dr. Simopoulos examined her and discussed the problem pregnancy with her. (Va. App. at 443a). She tearfully pleaded that her parents not be told. (Va. App. at 444a).

Dr. Simopoulos advised her and provided written follow-up instructions as to how she could abort in the emergency room of Fairfax Hospital. (Va. App. at 406a). First he injected saline solution, with a needle drip process, into her uterus. This solution, when it works, can cause contractions of the uterus similar to miniature labor. The injection can be safely done in a clinic, such as Dr. Simopoulos', as the uncontradicted medical

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[2] Although the evidence showed that the boyfriend was present during important conversations, and later in the motel, the prosecutor refused to provide his name to the defense.

testimony showed. One nationally known expert and three board certified northern Virginia gynecologists testified to this effect. The national experts, Dr. Harold Schulman, Ob/Gyn Department Chairman at Albert Einstein College of Medicine, had pioneered the technique in the early 1970's and published both a book and a separate study on the subject. (Va. App. at 16a).

Dr. Schulman and the three Northern Virginia gynecologists explained in great detail the advantages and safety of outpatient saline solution instillation, particularly in a facility equipped as well as the one of Dr. Simopoulos. (Va. App. at 81a, 152a-154a, 387a-389a).[3]

Meanwhile, after the saline instillation at the clinic, Patricia McDonald tried to leave her follow-up instruction behind. (Va. App. at 410a). These important instructions (Comm. Ex. 6, Va. App. at 369a), however, explicitly directed her to call Dr. Simopoulos in the event of bleeding or other problems. (*Id.*) They also advised here to call him and to proceed to the hospital when regular cramping and labor began. (*Id.*) These were the same instructions provided to patients who happened to have their saline injections within the walls of a hospital.

Miss McDonald and her boyfriend left the clinic and abandoned the direction of Dr. Simopoulos. She never called the clinic or in any way attempted to reach Dr. Simopoulos thereafter. (Va. App. at 326a). They went to a motel unknown to Dr. Simopoulos — the Howard Johnson's in Springfield, several miles away. At the motel Miss McDonald checked in and remained cut off

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[3] A recent national study from the University of North Carolina described how patients "spent the night in the motel unit" near the hospital after injection and before abortion. Grimes, *Midtrimester Abortion*, 137 AM. J. OB. GYN. 785 (1980).

from the outside world, until she aborted the fetus in her room two days later. (Va. App. at 326a). The events of those two days are unclear because Miss McDonald declined interviews, and the prosecutor refused to identify her boyfriend.

The testimony showed, as Miss McDonald admitted, that she required no medical attention after she aborted the fetus in the motel. (Va. App. at 344). After the abortion, she went home. She left the fetus, follow-up instructions, and pain medication behind. (Va. App. at 343a-345a).

Within a matter of days this prosecution began. A frightened Patricia McDonald cooperated fully with the police.

WHEN AND HOW THE FEDERAL QUESTIONS WERE RAISED AND DECIDED BELOW

Counsel raised, argued and preserved each of these federal questions whenever appropriate below. (Apps. A-D, *infra*). Both the Supreme Court of Virginia and the Circuit Court of Fairfax county expressly ruled upon each federal question. (*Id.*)

(1) At trial, after the prosecution case, and on appeal, counsel urged *United States* v. *Vuitch,* 402 U.S. 62 (1971), and other cases as authority for requiring the prosecutor to allege and prove that an abortion was not necessary for the life or health of the patient. (App. A at 9a-10a, 277 S.E.2d at 200). The prosecutor had alleged other co-equal exceptions to the total ban on abortion in Va. Code 18.2-71, but not the medical necessity exception of Va. Code 18.2-74.1.

Dr. Simopoulos contended that the reversed burden of proof violated his presumption of innocence and in-

vaded his priviiege against self-incrimination. This violated the due process clause of the Fourteenth Amendment. He pointed out that the prosecutor had control over the patient and the facts. (Motion to Dismiss, Va. App. at 199a-201a; Motion to Strike, Va. App. at 350a-354a; Assignment of Error IV). To rebut the presumption, Dr. Simopoulos absolutely had to take the stand.

The trial court and the Virginia Supreme Court rejected these federal constitutional arguments, relying instead on an early Virginia case, *Russo* v. *Commonwealth,* 207 Va. 251, 148 S.E.2d 820 (1966). The Virginia high court discussed none of the adverse, arguably contrary decisions from this Court. E.g., *Sandstrom* v. *Montana,* 422 U.S. 510, 511 (1979); *Tot* v. *United States,* 319 U.S. 463, 470 (1943).

(2) At the close of the prosecutor's case, and by motion at the end of all the evidence, counsel pointed out the total failure of proof on the essential element of *causation.* (App. A at 10a-11a; 277 S.E.2d at 200). The prosecutor never asked the medical examiner whether the saline injection *caused* the demise or expulsion of the fetus. He also never called any other expert witness. (Va. App. at 273a, 277a, 279a).

Dr. Simopoulos contended that the complete absence of proof on an essential element of the offense violated the due process clause of the Fourteenth Amendment, as in *Thompson* v. *Louisville,* 362 U.S. 199 (1960), and *Vachon* v. *New Hampshire,* 414 U.S. 478 (1974); cf. *Jackson* v. *Virginia,* 443 U.S. 307 (1979); *Commonwealth* v. *Edelin,* 371 Mass. 497, 359 N.E.2d 4 (1976) (no proof of intent); (App. A at 10a-11a; 277 S.E.2d at 200).

The trial court and the Virginia Supreme Court concluded that causation had not been excluded (App. A at 11a; 277 S.E.2d at 200). But that answered the wrong question. Neither court cited expert testimony or other medical evidence of causation. (*Id.*). The medical opinion questions were simply never asked. The case could not have gone to a jury in a civil malpractice matter, much less a felony prosecution. Both Virginia courts relied upon lay conjecture kindled by suspicion. (*Id.*) A fact-skeptical reading of page 200, 277 S.E.2d, exposes the due process violation in explicit terms. Something is missing. No qualified medical expert ever testified that the saline injection in fact caused the demise or expulsion of the fetus. No such witness was ever called or questioned by the prosecutor on this point, although it is an essential element of the offense.

(3) By pretrial motion, at the end of trial, and on appeal, counsel argued that the Virginia abortion law was unconstitutional. (App. A at 13a-19a; 277 S.E.2d at 201). This argument focused on the second trimester hospital requirement of the Virginia law. Dr. Simopoulos called several highly qualified medical and demographic experts who thoroughly explored the factual background of this question. The prosecutor called no experts.

Dr. Simopoulos contended that mandatory hospitalization singled out abortions for no good reason, burdened a woman's access to second trimester abortions, delegated to hospitals the right to exclude or unreasonably limit such abortions, and was not reasonably necessary to protect a patient's health, all in violation of the due process clause of the Fourteenth Amendment.

The trial court and Virginia Supreme Court rejected these arguments. (App. A at 19a; 277 S.E.2d at 201-04;

App. B at 23a; App. C at 27a). They are also not answered by the *Gary-Northwest*[4] summary affirmance because of the differing statutes, procedural status, and evidentiary records between the two cases. *Gary-Northwest* never went beyond the preliminary injunction stage.

THE QUESTIONS ARE SUBSTANTIAL

This appeal presents four recurring substantial federal questions which have not been formally decided by this Supreme Court. On each question the decision of the Virginia Supreme Court conflicts with the reasoning, if not the holdings, of one or more important decisions by this Court.

I. The Virginia Supreme Court Erred In Imposing The *Burden Of Proof* Upon Dr. Simopoulos To Establish Medical Necessity For The Abortion, In Violation Of the Due Process Clause And The Principles Laid Down In *United States* v. *Vuitch.*

The opening question was examined but left undecided insofar as state prosecutions are concerned in the D.C. abortion case, *United States* v. *Vuitch,* 402 U.S. 62 (1971). That burden of proof issue is a recurring one in the state appellate courts, where the results have varied. Compare the decision below with the contrary holdings in *State* v. *Jamieson,* 206 Kan. 491, 480 P.2d 87 (1971), and *Corkey* v. *Edwards,* 322 F.Supp. 1248, 1255 (W.D.N.C. 1971). Cf. *People* v. *Seaman,* 107 Mich. 348, 65 N.W. 203 (1895) (error to refuse instruction on possible natural causes of abortion).

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[4] *Gary-Northwest* v. *Bowen,* 451 U.S. _____ (1981), *aff'g mem.* 496 F.Supp. 894 (1980) (three-judge court).

The issue is whether the indictment should have alleged and the prosecutor proved that an abortion was not necessary for Patricia McDonald's life or health. Without such an allegation, proof, and argument, the prosecutor's case should have been insufficient to require the defense to go forward. The indictment could be proved and there be no crime because the element of Va. Code 18.2-74.1 was not excluded.

The courts below, however, wrongly *presumed* lack of necessity and required Dr. Simopoulos to take the stand and go forward on this issue. This was contrary to the principle of *United States* v. *Vuitch,* 402 U.S. 62, 71 (1971), that:

> "the burden is on the prosecution to plead and prove that an abortion was not 'necessary for the preservation of the mother's life or health.' "

This Court in *Vuitch* reasoned that it would be highly anomalous for a legislature to authorize abortions necessary for life or health, and then to demand that a doctor, upon pain of imprisonment, bear the burden of proving that an abortion he performed fell within that category.

Constitutional considerations also suggest that the prosecution must carry the burden of proving that the abortion was not necessary to save the woman's life. The *Vuitch* Court agreed:

> "Certainly a statute that outlawed only a limited category of abortions but 'presumed' guilt whenever the mere fact of abortion was established, would at the very least present serious constitutional problems under this Court's previous decisions interpreting the Fifth Amendment."

402 U.S. at 70. The Court cited *Tot* v. *United States,* 319 U.S. 463, 470 (1943) (Shift of burden of proof to rebut presumption that possession of firearm violates the firearms act abridges due process rights), and *Leary* v. *United States,* 395 U.S. 6, 26-29 (1969) (Placing burden on defendant of proving compliance with the Marihuana Fee Act violates privilege against self-incrimination). *Cf. Sandstrom* v. *Montana,* 442 U.S. 510 (1979).

In light of *Vuitch, Tot, Leary,* and *Sandstrom,* Question I is substantial and should be reviewed. The Virginia Supreme Court analysis of this issue is unpersuasive. It turns on the location of the exception in the statutory scheme. That is a sentence structure argument. It subordinates constitutional rights to the arrangement of sentences.

II. The Virginia Supreme Court Erred In Upholding The Conviction Because The Prosecution Neglected To Present Evidence That Any Act Of Dr. Simopoulos In Fact *Caused* The Demise Or Expulsion Of The Fetus.

The second question, absence of any proof of causation, also involves the fundamental due process guarantee of presumed innocence. This Court has frequently examined similar issues in cases that were disregarded by the Virginia high court. E.g., *Jackson* v. *Virginia,* 443 U.S. 307 (1979); *Vachon* v. *New Hampshire,* 414 U.S. 478 (1974); *Thompson* v. *Louisville,* 362 U.S. 199 (1960).

Here, the prosecution did not prove that the act complained of caused any result prohibited by statute. It utterly failed to show that instillation of the saline solution actually caused the woman to abort the fetus, or caused the fetal demise. In fact, the prosecutor abandon-

ed any such line of inquiry after objections were sustained. (Va. App. at 275a).

The Commonwealth presented the Medical Examiner as its sole witness on medical issues and the issue of causation. (Va. App. at 273a). He testified that the fetus "was born dead." (Va. App. at 273a). His report gave "immaturity" as the cause. (Va. App. at 277a). From the examination of the fetus itself, he could not say that the saline caused this fetus to be expelled to the exclusion of other instrumentalities. (Va. App. at 279a). No other medical person testified for the prosecutor on the issue of causation. Dr. Simopoulos had no opportunity to examine the fetus for rebuttal.

Proof of causation would have required evidence of the type of saline solution injected, the amount needed to cause an abortion, an examination of the fetus to show whether a saline injection caused its demise or the abortion, and an absence of intervening causes, in the two days Patty McDonald was secreted in the motel. No evidence was produced by the prosecutor on those issues.

Medical experts for Dr. Simopoulos agreed that not all saline injections caused the fetus to be expelled. At least three experts testified that a saline injection does not always cause a patient to abort the fetus. ((Va. App. at 394a (Soyster); Va. App. at 279a (Weicking); Va. App. at 22a (Schulman)). Further, Dr. Schulman explained how it is medically possible after saline is injected that there be some other factor that causes the patient to abort. (Va. App. at 36a).

The lower court was unpersuasive on this issue. It was beside the point when noting no "evidence of any other causative factor. . . ." (App. A at 11a; 277 S.E.2d

at 200). The issue was proof, not disproving. No proof was offered, only lay conjecture and suspicion.

Dr. Simopoulos should not be deprived of his liberty on the mere possibility that his action 48 hours earlier could have caused the expulsion or demise of the fetus. Conviction on such an unproven hypothesis is contrary to all tenets of our criminal law system.

III. The *Mandatory Hospitalization* Requirement Of The Virginia Abortion Law Abridges The Rights Of Privacy And Due Process By Unduly Restricting Access To Second Trimester Abortions And Delegating To Hospitals The Authority To Ban Such Abortions Altogether.

Questions III and IV concern the most fundamental problem of access to safe second trimester abortions when the state and hospitals combine to restrict that access.

Burden on right of privacy

A hospital requirement for initiation and/or completion of a second trimester abortion cannot be justified in medical, practical or constitutional terms. All of the experts testified at trial that performing a saline instillation in an outpatient facility is acceptable medical practice in the second trimester. (Va. App. at 19a, 83a, 155a, 386a). All had experiences with patients who delivered or aborted outside a hospital. (Va. App. at 81a, 154a-155a, 224a, 387a-388a). The prosecutor produced no evidence and no witnesses to refute this testimony.

Rather, the evidence at trial demonstrated that the law drastically limits a Virginia woman's access to mid-trimester abortion services. Only two hospitals in Northern Virginia permit second trimester procedures. (Va. App. at 118a). Both require parental consent for minor

women. (Va. App. at 83a, 117a, 388a). The Commonwealth also authorizes hospitals to prohibit performance of all abortions. Va. Code Sec. 18.2-75. There is nothing to support the conjecture below that the 24 hospitals (out of 95 total) which permit *some* abortions would automatically allow *second* trimester abortions for minors without parental consent. (App. A at 19a; 277 S.E.2d at 204). That statement came from nowhere, certainly not any evidence in the case.

Roe v. *Wade*, 410 U.S. 113 (1973), and *Planned Parenthood* v. *Danforth*, 428 U.S. 52 (1976), provide authority for striking down this law. *Roe* invalidated a hospital requirement for first trimester abortions in part because the procedure was considerably safer than childbirth. In *Danforth*, the Court made the same finding as to the safety of a saline instillation abortion. Thus, the *Roe* rationale for invalidating a hospital rule also applies to the second trimester.

Certain lower courts have already declared a second trimester hospital requirement unconstitutional. *See, e.g., Margaret S.* v. *Edwards*, 488 F.Supp. 182 (E.D. La. 1980); *Wolfe* v. *Stumbo*, No. C80-0285 L(A) (W.D. Ky. Dec. 3, 1980) (not yet reported).

Statute and procedural posture different from Gary-Northwest

Gary-Northwest v. *Bowen*, 451 U.S. _____ (1981), *aff'g mem.* 496 F.Supp. 894 (N.D. Ind. 1980) (three-judge court), was substantially different from this case and is not controlling.

This case is procedurally very different. It is before this Court on a fully documented record following a trial and judgment on the merits. The judgment affirmed in *Gary-Northwest* was an attempt to re-open a denial five

years earlier of a preliminary injunction against a different type of hospital requirement. Under Rule 60(b), the three-judge court refused to re-open the denial of the injunction. The procedural issues presented and decided by this Court in *Gary-Northwest* are not presented here. See Questions Presented, I, in the Jurisdictional Statement of *Gary-Northwest*.

The statutes involved in the two cases also demonstrate a significant distinction. The Indiana statute defines "hospital" to include ambulatory out-patient surgical centers, whereas the Virginia statute is more restrictive. Consequently, fewer Virginia facilities are available to perform second trimester abortions than in Indiana. Thus, the Virginia statute imposes a much more severe burden on the effectuation of a woman's decision to have an abortion.

Unlike *Gary-Northwest*, this appeal argues that the hospitalization statute is an unconstitutional *delegation* of uncontrolled discretion to hospitals. Such discretion permits both public and private hospitals to decide, without any standards, whether they will permit second trimester abortions to be performed in those institutions. Precedent forbids the state delegation of unlimited veto power to third parties. *See, e.g. Washington ex rel. Seattle Title Trust* v. *Roberge*, 278 U.S. 116 (1928); *Shuttlesworth* v. *Birmingham*, 394 U.S. 147 (1969); *Hallmark Clinic* v. *North Carolina Department of Human Resources*, 380 F.Supp. 1153 (E.D.N.C. 1974) (three-judge court), *aff'd on unrelated point*, 519 F.d 1315 (4th Cir. 1975). This due process issue was not presented or argued in *Gary-Northwest*.

Because of these distinctions, the summary affirmance in *Gary-Northwest* does not control or affect this appeal. A summary affirmance upholds the narrow judg-

ment of a lower court, not the reasoning. It controls only as to the "precise issues presented and necessarily decided" by this Court. *Illinois State Board of Elections* v. *Socialist Workers Party*, 440 U.S. 173, 182-83 (1979); *Mandel* v. *Bradley*, 432 U.S. 173, 176 (1977).

There was never a full trial or final judgment on the second trimester hospital rule in *Gary-Northwest*. The September 1976 decision and judgment spoke to parental consent and nothing more. The January 1975 ruling denied only a preliminary injunction against the hospital requirement. The 1980 ruling refused to reopen that of January 1975. The *Gary-Northwest* Jurisdictional Statement presented three questions to the Court, none of which addressed the merits.

The Court in *Gary-Northwest* could not reach the merits of the second trimester requirement. It necessarily decided only that the district court did not erroneously refuse to re-open the 1975 question and that it did not abuse its discretion in denying a preliminary injunction against a second trimester hospital requirement. A decision on the abuse of discretion in denying or granting a preliminary injunction or re-opening a question under 60(b) is not the same as a judgment on the merits. *University of Texas* v. *Camenisch*, 451 U.S. _____ (1981). As this Court stated in *Camenisch*:

> "(W)here a . . . court has granted (or denied) a preliminary injunction, the parties generally will have had the benefit neither of a full opportunity to present their cases nor of a final judicial decision based on the actual merits of the controversy." *Id.* at _____.

This important question should be given plenary review on this appeal.

Standard of review

The Virginia Supreme Court also applied an erroneous standard of review. It relied upon

> "a presumption of constitutionality . . . (The) burden rests upon those who question their validity to overcome the presumption." (App. A at 19a; 277 S.E.2d at 204).

Strict judicial scrutiny, however, is the proper review standard for midtrimester abortion laws or regulations. This Court has consistently applied a stringent standard to provisions limiting the abortion decision and its effectuation at this stage of pregnancy.

Harris v. *McRae*, 448 U.S. 297 (1980), recently explained the test applicable to such laws:

> "It is well settled that, quite apart from the guarantee of equal protection, if a (regulation) 'impinges' upon a fundamental right explicitly or implicitly secured by the Constitution (it) is *presumptively unconstitutional.*' "

Id. at _____. (Emphasis added).

The statute in question directly impacts on the fundamental right of privacy. It restricts the woman's access to non-hospital facilities in the second trimester. Similarly, the provision penalizes the physician who would choose a non-hospital facility.

To overcome this "presumptively unconstitutional" standard, the law must meet the stringent test enunciated in *Roe* v. *Wade*, 410 U.S. 113 (1973). The Commonwealth must establish that the law serves a compelling state interest *and* is narrowly tailored to further that interest. *Id.* at 155. The same strict test applies to regulations substantially limiting access to the means of effec-

tuating the abortion decision as to laws prohibiting the decision completely. *Carey* v. *Population Services International*, 431 U.S. 678 (1977).

Danforth demonstrates this Court's willingness to closely examine a second trimester restriction. There the State justified a law banning saline instillation as reasonable to promote maternal health. The State asserted the Court must defer to its medical findings. The Court refused to do so. Instead, it rigorously scrutinized the law and reexamined the insupportable and speculative findings of the legislature. The Court then struck down the statute.

Colautti v. *Franklin*, 439 U.S. 379 (1979), also strictly scrutinized laws concerning abortions performed later in the pregnancy. A close analysis is necessary here to avoid a decision with unreasonable, unnecessary, and unconscionable results.

IV. The Mandatory Hospital Rule Further Violates Due Process In This Case Because The Patient Was A Mature Minor In Jeopardy Of Parental Retribution, And The Only Available Hospital Required Parental Consent.

The final substantial federal question here arises from the unusual configuration of facts.

In essence, the hospital requirement delegates control over second trimester abortions to the 95 hospitals in the Commonwealth. Only 26 (27.4%) of those hospitals permit any abortions at all. Only 2 hospitals in northern Virginia permit any second trimester abortions. Both of those require parental consent for minors in the manner prohibited by *Planned Parenthood* v. *Danforth*, 428 U.S. 52 (1976).

Contrary to the assertion below (App. A at 19a; 277 S.E.2d at 204), the obstacle of parental consent is the responsibility of the Commonwealth which created the statutory scheme. Virginia delegates to the hospitals all control over second trimester abortions, including authority to exclude "any patient" seeking an abortion. Va. Code 18.2-75 (conscience clause).

More important, however, is the fact that the Commonwealth first channels all second trimester abortions into the hospitals, and then imposes felony sanctions on those who cannot or do not use the hospital.

If every Virginia hospital excluded all abortions, as is virtually the case for any minor, then surely this Court would see the obvious result was prohibited by *Roe* v. *Wade*, 410 U.S. 113 (1973). Here, the class of minors represented by Patricia McDonald was in fact totally excluded in northern Virginia. The Commonwealth is responsible because it forces the unconstitutional result and penalizes those who do not adhere to the impossible statutory mandate.

If the state delegation of authority to hospitals were not so sweeping and without guidelines, the question would be different. If the state allowed non-hospital second trimester abortions, as do all the other Fourth Circuit states, the question again would be a closer one. Virginia, however, has chosen the most restrictive alternative and backed it with severe felony sanctions that cause automatic revocation of a physician's license.

As applied to this case of a minor, the statute raises important, recurring federal questions which should be reviewed on appeal.

CONCLUSIONS

For the reasons set out, the Court should note probable jurisdiction and set this case for briefing and argument.

Respectfully Submitted:

ROY LUCAS
Counsel of Record

Roy Lucas & ASSOCIATES, P.C.
Suite 424
1055 Thomas Jefferson St., N.W.
Washington, D.C. 20007
(202) 338-6955

Attorneys for Appellant.

Dated: July 29, 1981.

Appendix

APPENDIX A: OPINION OF VIRGINIA SUPREME COURT

FROM THE CIRCUIT COURT OF FAIRFAX COUNTY

Record No. 801107

CHRIS SIMOPOULOS, M.D.

v.

COMMONWEALTH OF VIRGINIA

Present: Carrico, C.J., Harrison, Cochran, Poff, Compton, Thompson, J.J.

F. BRUCE BACH, *Judge*

OPINION BY JUSTICE RICHARD H. POFF

April 24, 1981

Chris Simopoulos, a medical doctor licensed to practice obstetrics and gynecology, appeals from a judgment convicting him of a violation of the abortion statutes. The trial court heard the evidence without a jury and sentenced him to two years' imprisonment suspended during good behavior upon condition he serve 30 days in jail.

P.M., a 17 year-old female, made an appointment to see the defendant at his clinic on November 8, 1979. She told him that she was pregnant, that she was not married, and that she had decided to have an abortion. The defendant inquired whether she had discussed the matter with her parents, and she replied that she had been afraid to do so. The defendant examined her, informed her that she was five and one-half months pregnant, and agreed to perform an abortion by

means of an injection of a "saline solution".[1] P.M. told him that she intended to deliver the fetus in a motel, and the defendant assured her that "it was okay".

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[1] This is a reference to saline amniocentesis, a means commonly employed in second-trimester abortion procedures. It was described as follows in a medical journal article offered at a pre-trial hearing:

> "The technic utilized has been uniform. The patient assumes the supine position, and the abdomen is exposed. No premedication is used. The abdomen is cleansed, and a point representing the middle of the fundus of the uterus is identified. The skin, fascia and peritoneum are then anesthesized [*sic*] with 1 or 2% lidocaine. The amniotic cavity is entered with a 14-guage thin-wall needle, and the stylet is removed. If a free flow of amniotic fluid ensues, a No. 5F Teflon catheter is threaded through the needle several centimeters beyond its tip. . . . The needle is then removed, and the rest of the procedure is carried out through the catheter.
>
> "An effort is then made to remove all of the fluid in the uterus. After this is done, a 20% NaCl (sodium chloride) solution is injected into the uterus. If fluid is not obtained easily, an exchange infusion is performed — saline is instilled and then an equal amount of fluid is removed. This process is repeated until the operator is certain that there is sufficient NaCl within the amniotic cavity. The maximum quantity injected should be 200 ml, which is 40 g of NaCl. A smaller volume is injected into smaller uteri when less fluid has been aspirated. Although the minimum quantity necessary to terminate all pregnancies has not been determined, we estimate that not less than 120 ml of 20% solution should be injected.
>
> "At the end of the procedure, one million units of aqueous penicillin is instilled. In addition to providing prophylaxis, this instillation clears the catheter of the salt solution which is caustic to the peritoneum. The patient should experience no discomfort during the procedure.
>
> "Symptoms of hypernatremia — headache, heat, thirst, numbness and tingling of the fingers — are an absolute indication for the operator to stop to re-evaluate the procedure. If the patient feels pain when saline is being injected, then the solution is being injected into tissue and, once again, the procedure must be interrupted and re-evaluated. The average time used for the entire process is 20 minutes."

Schulman, et al, "Outpatient Saline Abortion", 37 *Obstetrics & Gynecology* 521, 522 (1971).

On the morning of November 10, P.M. returned with her boyfriend to the clinic and, using money she had acquired through her VISA credit card, she paid the agreed fee of $475. The defendant administered a local anaesthetic, injected a saline solution into her amniotic cavity, and gave her a "Post-Injection Information" sheet and a prescription for percodan, an analgesic. The sheet advised her that she had undergone "a surgical procedure" and warned her of "a wide range of normal reactions", including contractions, backache or tenderness at the bottom of the abdomen, nausea, thirst, dizziness, expulsion of amniotic fluid, rupture of "the bag of waters", and bleeding. The sheet directed her to abstain from alcoholic beverages and sexual activity, to call the doctor if "heavy bleeding began, and to come to the hospital when labor contractions became frequent or when the bag of waters broke.

That afternoon, P.M. and her boyfriend filled the prescription and rented a room in a motel near the clinic. P.M.'s boyfriend stayed with her until 3:00 a.m. the next morning, returned at noon, and left again at 10:00 p.m. that night. Shortly after midnight, P.M. experienced the onset of labor. About 11:00 a.m. that morning, she expelled the fetus, placed it and the afterbirth in a bathroom trashcan, and left for home. P.M. testified that she had eaten "some peanut butter and jelly sandwiches" and smoked a few cigarettes while awaiting her labor. She denied that she had ingested any drugs or medication except the percodan. She admitted that she never intended to abort in the hospital. Asked if the defendant had instructed her to abort in a motel, she said that "[h]e told me that it was possible, that I didn't have to go to a hospital" and "[h]e made it perfectly clear what he meant." Responding to another question, she denied that the defendant had promised to meet her at the hospital after the contractions started.

In the course of our opinion, we will detail other facts relevant to the multiple issues framed on appeal. These include the validity of the indictment, the sufficiency of the

evidence to prove criminal intent and causation, the denial of discovery motions, and the exclusion of certain testimony. Aside from the constitutional questions underlying these issues, the defendant questions the constitutionality of the hospital requirement of the statutes under which he was indicted and convicted.

I. Construction Of The Statutes

The defendant urges us to construe Article 9, Chapter 4, Title 18.2 of the Code as a whole. Doing so, we paraphrase the eight statutes out in the margin.[2]

[2] §18.2-71. Producing abortion or miscarriage, etc.; penalty. — Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony. (Code 1950, §18.1-62; 1960, c. 358; 1970, c. 508; 1975, cc. 14, 15.)

§18.2-72. When abortion lawful during first trimester of pregnancy. — Notwithstanding any of the provisions of §18.2-71, it shall be lawful for any physician licensed by the Virginia State Board of Medicine to practice medicine and surgery to terminate or attempt to terminate a human pregnancy or aid or assist in the termination of a human pregnancy by performing an abortion or causing a miscarriage on any woman during the first trimester of pregnancy. (1975, cc. 14, 15.)

§18.2-73. When abortion lawful during second trimester of pregnancy. — Notwithstanding any of the provisions of §18.2-71 and in addition to the provisions of §18.2-72, it shall be lawful for any physician licensed by the Virginia State Board of Medicine to practice medicine and surgery, to terminate or attempt to terminate a human pregnancy or aid or assist in the termination of a human pregnancy by performing an abortion or causing a miscarriage on any woman during the second trimester of pregnancy and prior to the third trimester of pregnancy provided such procedure is performed in a hospital licensed by the State Department of Health or under the control of the State Board of Mental Health and Mental Retardation. (1975, cc. 14, 15.)

1. A person who destroys a woman's unborn child, or causes her to abort or miscarry, by the use of any substance or by any other means with intent to achieve such a result is

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§18.2-74. When abortion or termination of pregnancy lawful after second trimester of pregnancy. — Notwithstanding any of the provisions of §18.2-71 and in addition to the provisions of §§18.2-72 and 18.2-73, it shall be lawful for any physician licensed by the Virginia State Board of Medicine to practice medicine and surgery to terminate or attempt to terminate a human pregnancy or aid or assist in the termination of a human pregnancy by performing an abortion or causing a miscarriage on any woman in a stage of pregnancy subsequent to the second trimester provided the following conditions are met:

(a) Said operation is performed in a hospital licensed by the Virginia State Department of Health or under the control of the State Board of Mental Health and Mental Retardation.

(b) The physician and two consulting physicians certify and so enter in the hospital record of the woman, that in their medical opinion, based upon their best clinical judgment, the continuation of the pregnancy is likely to result in the death of the woman or substantially and irremediably impair the mental or physical health of the woman.

(c) Measures for life support for the product of such abortion or miscarriage must be available and utilized if there is any clearly visible evidence of viability. (1975, cc. 14, 15.)

§18.2-74.1 Abortion, etc., when necessary to save life of woman. — In the event it is necessary for a licensed physician to terminate a human pregnancy or assist in the termination of a human pregnancy by performing an abortion or causing a miscarriage on any woman in order to save her life, in the opinion of the physican so performing the abortion or causing the miscarriage, §§18.2-71, 18.2-73 and 18.2-74 shall not be applicable. (Code 1950, §18.1-62.3; 1970, c. 508; 1975, cc. 14, 15.)

§18.2-75. Conscience clause. — Nothing in §§18.2-72, 18.2-73 or 18.2-74 shall require a hospital or other medical facility or physician to admit any patient under the provisions hereof for the purpose of performing an abortion. In addition, any person who shall state in writing an objection to any abortion or all abortions on

guilty of a Class 4 felony, unless the procedures employed and the result achieved are made lawful by other provisions of Article 9. §18.2-71.

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personal, ethical, moral or religious grounds shall not be required to participate in procedures which will result in such abortion, and the refusal of such person, hospital or other medical facility to participate therein shall not form the basis of any claim for damages on account of such refusal or for any disciplinary or recriminatory action against such person, nor shall any such person be denied employment because of such objection or refusal. The written objection shall remain in effect until such person shall revoke it in writing or terminate his association with the facility with which it is filed. (Code 1950, §18.1-63.1; 1974, c. 679; 1975, cc. 14, 15.)

§18.2-76. Informed consent required. — Before performing any abortion or inducing any miscarriage or terminating a pregnancy as provided for in §§18.2-72, 18.2-73 or 18.2-74, the physician shall obtain the informed written consent of the pregnant woman; provided, however, if such woman shall be incompetent as adjudicated by any court of competent jurisdiction or if the physician knows or has good reason to believe that such woman is incompetent as adjudicated by a court of competent jurisdiction, then only after permission is given in writing by a parent, guardian, committee, or other person standing in loco parentis to such incompetent, may the physician perform such abortion or otherwise terminate the pregnancy.

The physician shall inform the pregnant woman of the nature of the proposed procedure to be utilized and the risks, if any, in her particular case to her health in terminating or continuing the pregnancy. (Code 1950, §18.1-62.1; 1970, c. 508; 1972, c. 823; 1975, cc. 14, 15; 1979, c. 250.)

§18.2-76.1. Encouraging or promoting abortion. — If any person, by publication, lecture, advertisement, or by the sale or circulation of any publication, or through the use of a referral agency for profit, or in any other manner, encourge or promote the performing of an abortion or the inducing of a miscarriage in this State which is prohibited under this article, he shall be guilty of a Class 3 misdemeanor. (Code 1950, §18.1-63; 1960, c. 358; 1972, c. 725, cc. 14, 15.)

2. The process criminalized by §18.2-71 is lawful when performed in the first trimester of pregnancy. §18.2-72.

3. Such process is lawful during the second trimester when performed by a licensed physician in a licensed hospital. §18.2-73.

4. In the third trimester, the abortion process is lawful if: (a) it is performed by a licensed physician in a licensed hospital; (b) three physicians certify of record that a continuation of the pregnancy is likely to cause the woman to die or suffer substantial and permanent impairment of mental or physical health; and (c) fetal life support measures are available and utilized when there is clearly visible evidence that the fetus is viable. §18.2-74.

5. The proscribed process is lawful at any time during pregnancy if, in the opinion of the attending physician, such process is necessary to save the woman's life. §18.2-74.1.

6. Hospitals and physicians are not required to perform any process authorized by Article 9, and persons who register conscientious objections may refuse to participate in the procedures and are protected against damage suits and other recriminatory actions growing out of such refusal. §18.2-75.

7. No process otherwise authorized under Article 9 may be performed without the informed written consent of the woman or, when she has been adjudged imcompetent, one authorized to act for her. §18.2-76.

8. Any person who promotes or induces the performance of a process prohibited by Article 9 is guilty of a Class 3 misdemeanor. §18.2-76.1.

II. Validity Of The Indictment

Referencing §18.2-71, the indictment charged that the defendant "did unlawfully and feloniously, during the second trimester of pregnancy and outside of a hospital licensed by the State . . . use means upon a white female, aged 17, with the intent to produce abortion and thereby destroy her unborn child."

In a pre-trial motion to dismiss, the defendant alleged that the indictment "fails to state a valid offense". On appeal, he raises three challenges to the validity of the indictment.

A. Criminal intent

First, the defendant points out that the indictment did not charge that he acted "with the specific intent that the patient abort outside the hospital", and, he says, the evidence failed to establish such intent. Construing §§18.2-71, -73 together, the defendant maintains that, absent such a charge, the indictment is fatally defective.

The defendant's construction rests upon his impression that the definition of "abortion" contemplated by Article 9 is "expulsion of the fetus". That is a misimpression. "[T]he crime denounced is not limited to abortion in its narrow meaning of expulsion of the fetus, but includes . . . the use of any means with intent to destroy an unborn child, resulting in the destruction of such child." *Coffman* v. *Commonwealth*, 188 Va. 553, 561-62, 50 S.E.2d 431, 436 (1948). Both the means and the ensuing process, though proscribed by §18.2-71, are made lawful by §18.2-73 when performed in the second trimester, "provided such procedure is performed in a hospital". Dr. Peter Soyster, a practicing gynecologist, agreed at trial that the injection of a saline solution into the amniotic cavity of a pregnant woman is "a procedure to terminate her pregnancy". In our view, that statutory proviso applies to all procedures performed during the entire process, including the means employed with intent to initiate the process. The indictment expressly charged that the defendant employed such means with such intent. It was unnecessary to charge that he intended his patient to expel the fetus outside a hospital.

B. Duty to preserve fetal life

Because the statute referenced by the indictment forbids destruction of the fetus, the defendant argues that the indictment unconstitutionally burdens him with a duty to preserve

the life of the fetus. It is true that a statute which imposes a duty upon a physician to take affirmative action to preserve a fetus, irrespective of the stage of pregnancy and the viability of the fetus, is constitutionally impermissible. *Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52, 83 (1976). But after viability, the sovereign has a "compelling interest" sufficient to justify regulation reasonably designed to preserve the life of the fetus. "If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother." *Roe* v. *Wade*, 410 U.S. 113, 163-64 (1973).

We do not agree that the statutory proscription against destruction of the fetus is a command to preserve it. While §18.2-74(c) requires a physician to utilize fetal life support measures during the third trimester "if there is any clearly visible evidence of viability"[3], nothing in Article 9 imposes such an affirmative duty during the pre-viable stages of pregnancy, and we find no merit in the defendant's second argument.

C. Medical necessity defense

In a third argument, the defendant contends that the indictment is defective because it "does not attempt to negate the exception . . . of a medical necessity to treat the patient".

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[3] In *Colautti* v. *Franklin*, 439 U.S. 279 (1979), the Supreme Court reviewed a statute which imposed a fetal-preservation duty upon a physician if he determined that the fetus "is viable or may be viable". Id. at 380, n. 1. Finding that "it is unclear whether the statute imports a purely subjective standard, or a mixed subjective and objective standard" and that "it is uncertain whether the phrase 'may be viable' simply refers to viability or whether it refers to an undefined penumbral or 'gray' area prior to the stage of viability", *id.* at 397, the Court struck down the statute as impermissibly vague. There is nothing unclear or uncertain in the language of Code §18.2-74(c), and the standard it prescribes is purely objective.

This omission, the defendant says, shifts the burden of proving the exception to him in violation of the Supreme Court's ruling in *United States* v. *Vuitch*, 402 U.S. 62 (1971). There, the accused was charged with violation of a statute in which the enacting clause proscribed abortion "unless the same were done as necessary for the preservation of the mother's life or health". *Id.* at 67-68. The Court stated and then applied the rule that "when an exception is incorporated in the enacting clause of a statute, the burden is on the prosecution to plead and prove that the defendant is not within the exception". *Id.* at 70.

But when, as here, the exception is "made in a substantive clause subsequent to the enacting clause of the statute, . . . we hold it to be a matter of defense for the defendant to assert and not for the indictment to deny." *Russo* v. *Commonwealth*, 207 Va. 251, 259, 148 S.E.2d 820, 826 (1966).

The rule in *Russo* is not inconsistent with that in *Vuitch*. Once a defendant invokes §18.2-74.1 as a defense, the Commonwealth has the burden of negating maternal health necessity beyond a reasonable doubt. In a related argument, the defendant says that he raised the defense in his testimony and that the Commonwealth's evidence was insufficient to establish the absence of necessity. The defendant testified that his patient appeared "upset" and "depressed" when he examined her and that he became concerned about the possibility of suicide. But his patient, who acknowledged that her principal concern was to abort without her parents' knowledge, testified that she was "[s]cared, but nothing else." Furthermore, the defendant's handwritten notes in the clinic's records described P.M.'s condition as "normal" and showed that the saline procedure was "performed without any complications". We find such evidence fully sufficient to refute any claim of maternal health necessity.

III. Causation

Attacking both the validity of the indictment and the sufficiency of the evidence, the defendant declares that the Com-

monwealth failed to allege and to prove "that instillation of the saline solution actually caused the woman to abort the fetus." But "[a] close reading of [§18.2-71] will disclose that it is in two parts." *Anderson* v. *Commonwealth*, 190 Va. 665, 671, 58 S.E.2d 72, 74 (1950). The defendant reads only one part. Affirming a conviction in a case where the expectant mother died and the fetus was never expelled, we said:

> "[M]ore than one intended consequence is included. If only the intent to cause an abortion, in the sense of expulsion of the fetus, and the causing of such abortion, were meant to be covered, the words 'intent to destroy her unborn child,' and 'thereby destroy such child', would be useless. It is not to be presumed that those words were used for no purpose and mean nothing in the statute."

Coffman v. *Commonwealth, supra,* 188 Va. at 561, 50 S.E.2d at 435. Given this construction of the statute, the Commonwealth had the option of alleging and proving that the saline injection caused *either* the death of the fetus *or* the expulsion of the fetus.

By referencing the statute, the indictment fairly charged that the defendant's intentional act had caused the destruction of the fetus. Assessing the evidence, we note that the defendant readily acknowledged that he administered the saline solution with intent to terminate pregnancy and that he realized that the procedure would destroy the fetus. P.M. testified that, before she left the clinic, "he told me . . . that the fetus was destroyed". The medical examiner who performed the autopsy reported that the fetus was "born dead".

Absent evidence of any other causative factor, we are of opinion that the evidence was sufficient to show that the saline injection caused the destruction of the fetus. While it is reasonable to infer that the fetus was expelled because it was dead, we need not decide whether the Commonwealth proved a causal connection between the injection and the expulsion. That question is immaterial to the offense with which the defendant was charged.

IV. Pre-Trial Discovery Requests

In pre-trial motions, the defendant made several general and specific requests for discovery. The trial court ruled that "I am going to require [the Commonwealth's Attorney] to give you everything . . . that in any way could be exculpatory." The Commonwealth's Attorney declared that he had no exculpatory information.

On appeal, the defendant complains that the Commonwealth withheld an extra-judicial statement the patient made to the police and "the names of two important witnesses", one, the patient's boyfriend, and the other, the physician who examined her at a military hospital a few days after the fetus was expelled.

"[T]he suppression by the prosecution of evidence favorable to an accused upon request violates due process where the evidence is material either to guilt or to punishment. . . ." *Brady* v. *Maryland*, 373 U.S. 83, 87 (1963). Due process requires disclosure when the evidence requested is such as "would tend to exculpate [the accused] or reduce the penalty". *Id.* at 88.

The defendant maintains that the information he sought was material to show whether the expulsion resulted from some cause other than the saline injection.[4] While we note that the defendant did not consider the information sufficiently important to seek it by subpoenaing the records of the military hospital or by interrogating the knowledgeable witnesses at the preliminary hearing or at trial, we will assume that P.M.'s statement and the names of the boyfriend and the physician were matters relevant to the question whether the

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[4] Arguing his motions in the court below, he explained that the information was necessary to determine if his patient had "had any other procedure performed that could have caused the expulsion or if she took any drug or did anything of any nature that would be an intervening superseding cause".

saline injection caused the expulsion of the fetus.[5] But, as we have said, since the evidence of record is sufficient to prove that the injection caused the destruction of the fetus, that question is immaterial to the offense charged in the indictment. It follows that the information requested was not constitutionally material to guilt or punishment, and we reject the defendant's complaint.

V. The Hospital Requirement

The principal constitutional challenge is addressed to the hospital requirement of §18.2-73. The defendant's attack is twofold. First, he argues that the requirement violates the Due Process clause because, he says, it is not reasonably related to matern health and, therefore, transcends the regulatory powers of the state. Second, he contends that it limits a pregnant woman's access to medical care, and thus, abridges her constitutional right to choose abortion over maternity.

In the definition of a woman's right to abort, the watershed case is *Roe* v. *Wade*, 410 U.S. 113 (1973). There, the Supreme Court, referring to the First, Fourth, Fifth, Ninth, and Fourteenth Amendments as "the roots" of a constitutional right of privacy, held that the right "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." *Id.* at 153. Classifying that right as one of the "fundamental rights", the Court said that state "regulation limiting these rights may be justified only by a 'compelling state interest.' ". *Id.* at 155. Balancing the personal right of privacy against the state's power to regulate, the Court explained:

> "[T]he State does have an important and legitimate interest in preserving and protecting the health of the preg-

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[5] "The mere possibility that an item of undisclosed information might have helped the defense does not establish 'materiality' in the constitutional sense." *United States* v. *Agurs*, 427 U.S. 97, 109-10 (1976).

nant woman . . . and . . . it has still *another* important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes 'compelling.'

"With respect to the State's important and legitimate interest in the health of the mother, the 'compelling' point . . . is at approximately the end of the first trimester. This is so because of the now-established medical fact . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.

"This means, on the other hand, that, for the period of pregnancy prior to this 'compelling' point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State."

"With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability. . . ."

Id. at 162-63.

Doe v. *Bolton*, 410 U.S. 179 (1973), was decided the same day as *Roe*. Finding that the evidence adduced at trial was insufficient to show that a hospital requirement in a Georgia statute was reasonably related to maternal health, the Court ruled that the regulation was invalid "because it fails to exclude the first trimester of pregnancy". *Id.* at 195. Article 9 of the Virginia Code excludes the first trimester; the hospital requirement applies to the second and third trimesters only. Under the principles and the standard of review announced in *Roe* and *Doe* we consider whether the evidence in this case supports a conclusion that "the regulation reasonably relates to the preservation and protection of maternal health." *Roe*, 410 U.S. at 163.

A. Maternal health

Contending that it does not, the defendant points to the testimony of several medical experts. Dr. Harold Schulman testified that saline injections are often administered in ill-equipped treatment rooms at hospitals from which the patient is discharged to await labor. He suggested that hospitalization during the waiting period is not necessarily wise and could be dangerous to an expectant mother. He mentioned the possibility that some members of a hospital staff might be unsupportive or critical of unwed mothers and some might attempt to hasten expulsion by manipulation or instrumentation and thereby cause uterine or cervical perforation. A study he conducted showed that 65 percent of those injected as outpatients expelled the fetus at home, enroute to the hospital, or upon arrival and thereafter required no hospitalization.

Yet, on cross-examination, Dr. Schulman conceded that the saline injection procedure entails certain risks which make it necessary to observe the patient to "see if there are any unusual reactions to the instillation of the solution." Such reactions may occur "for some unexplained reason" or when "a disproportionate amount of the salt solution somehow gets into her blood stream." This can cause "thirst or headache, nausea, vomiting and on rare occasions the uterus will abrupt-

ly begin to swell." Dr. Schulman agreed that the saline solution can interfere with the clotting capacity of the blood and result in extensive hemorrhaging. He characterized this as a "very serious problem", but one which occurs "for the most part" only during labor. He was familiar with some reported cases of maternal death due to "total evacuation of blood". Although he felt that the defendant's clinic was better furnished than most facilities used for saline procedures, he recalled that it was not equipped to handle blood transfusions. In his own practice, Dr. Schulman instructs patients injected with saline to "go to the hospital" when labor begins. He follows this policy "because of the danger that's inherent in this whole process."

Dr. Samuel M. Belinsky testified that he had administered 93 second-trimester saline injections in a treatment room at Fairfax Hospital. As appears from his testimony, Dr. Belinsky considers an out-patient saline injection "a reasonably safe medical procedure"; he agrees that the defendant's clinic is adequately equipped for the procedure; he finds that the complication rates are "about the same" whether the procedure is performed on an in-patient or out-patient basis; he believes it is medically reasonable to release a saline patient following a period of observation, with instructions such as those given by the defendant; and he has some concern about the possibility of patient abuse by hospital staffs.

On direct examination, Dr. Thomas Gressinger concurred generally in Dr. Belinsky's opinions. On cross-examination, however, he acknowledged that, if the saline solution enters the bloodstream too fast, it may cause "hypernatremia". Although that condition may be corrected before the onset of labor by the body's natural defense mechanisms, he agreed that, when bleeding results, it is a "major medical problem". He noted that Fairfax Hospital maintains a special facility apart from the operating room for delivery of patients injected with saline. Dr. Gressinger, who had administered numerous injections at that hospital, advises his patients to deliver there. He said that the saline process "should be close-

ly supervised and the facility is set up for close supervision." "I feel," he added, "it's the best facility around so I feel it's best for my patients."

Testifying in his own defense, the defendant was of opinion that the saline procedure is the safest method of abortion, that it rarely causes significant complications, that his clinic is properly equipped to perform the procedure, and that the statutory hospital requirement is medically unnecessary for the protection of the patient. The testimony of Dr. Soyster, a witness for the defense, was to the same effect.

It appears that the saline method is the procedure most commonly employed by physicians to induce an abortion in the second trimester. Indeed, "saline amnio-infusion [is] the method of choice" during that stage of pregnancy. See *Colautti* v. *Franklin*, 439 U.S. 379, 398 (1979). And a statutory clause which forbids its use after the first trimester is not reasonably related to maternal health. *Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52, 78-79 (1976). But the method employed is not the issue here. Rather, the question is whether the state can require that the method chosen to initiate a second-trimester abortion be performed in a hospital.

As *Roe* and *Doe* teach, once pregnancy has entered the second trimester, the state has a compelling interest in maternal health. In the exercise of the regulatory powers of the state, the legislature may adopt any measure reasonably designed to reduce health hazards inherent in the performance of medical practices.[6] Here, unlike the situation in *Doe*, the medical evidence shows that, from the moment a saline solu-

---

[6] "The State has a ligitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of aftercare, and to adequate provision for any complication or emergency that might arise." *Roe*, 410 U.S. at 150.

tion is injected to the time the fetus is expelled, the pregnant woman is exposed to certain risks[7] — some minor, others major, none precisely predictable. The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health.

B. Hospital access

Advancing an alternative theory, the defendant insists that the hospital requirement is constitutionally defective because, he says, it unreasonably limits a pregnant woman's access to medical care and thereby abridges her right under *Roe* to elect to abort. Dr. Soyster testified that only two hospitals in Northern Virginia permit second-trimester abortions, and Dr. Belinsky knew of none in that area that did not require parental consent for abortions on minors. Noting that his patient, a minor, was anxious to conceal her condition from her parents and that she was unable to afford the expense of hospitalization, the defendant maintains that hospital access was "virtually unavailable". This, he argues, shows that the hospital requirement is unreasonable as applied in this State.

The defendant cites two opinions of federal district courts in other states. In *Margaret S.* v. *Edwards*, 488 F.Supp. 181

---

[7] The Attorney General appended to his brief certain medical journals to show additional risks inherent in the use of the saline procedure, and the defendant cited other papers discounting the risk. None of these articles (except one offered by the defendant) was introduced for the benefit of the trial judge. Those outside the record do little more than illustrate diversity of medical opinion, and we do not rely upon them in reaching our decision.

(E.D. La. 1980), none of the Lousiana hospitals performed second-trimester abortions. In *Planned Parenthood Ass'n of Kansas City* v. *Ashcroft,* 483 F.Supp. 679 (W.D. Mo. 1980), *argued,* No. 80-1130 (8th Cir. Nov. 17, 1980), only one hospital in Missouri did so. But, as acknowledged by the defendant on brief, two hospitals in Northern Virginia and 24 hospitals located elsewhere in the State were providing abortion services in 1977.

More to the point, to the extent access to hospital abortion services was inconvenient or conditioned upon parental consent, the limitations were not obstacles created by the state.[8] While Code §18.2-75, the so-called "conscience clause", *permits* private hospital corporations to place certain restrictions on abortion services or to refuse them altogether, it does not *require* them to do so. And it need not forbid them to do so. "[A]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation." *Harris* v. *McRae,* 100 S.Ct. 2671, 2688 (1980) (rejecting the contention that denial of public funding of abortion services was an unconstitutional infringement of the right to abort). *See also Poelker* v. *Doe,* 432 U.S. 519 (1977); *Maher* v. *Roe,* 432 U.S. 464 (1977); *Beal* v. *Doe,* 432 U.S. 438 (1977). Applying that rule, we reject the defendant's contention here.

Courts accord legislative enactments a presumption of constitutionality, and the burden rests upon those who question their validity to overcome the presumption. We find that the defendant has not carried his burden, and we hold that the hospital requirement of Article 9 is constitutionally permissible.[9]

[8] When imposed by the state, spousal and parental consent requirements are unconstitutional. *Danforth,* 428 U.S. at 67-75; *cf. H. L.* v. *Matheson,* 49 U.S.L.W. 4255 (March 23, 1981) (upholding statutory requirement that physician notify parents of a minor incapable of giving informed consent).

[9] Several other courts have reached a similar conclusion. *See, Gary-Northwest Indiana Women's Service, Inc.* v. *Bowing,* 496 F.

VI. Excluded Testimony

The defendant proffered, but the trial court excluded, the testimony of Dr. Emily Moore, an expert in demographics and family planning. Dr. Moore had made some 40 telephone calls to Northern Virginia hospitals inquiring about their administrative policies concerning second-trimester abortions. She experienced some difficulty in obtaining responsive and reliable information, but she concluded that only two area hospitals permit second-trimester abortions and that both require parental consent when the patient is a minor.

We believe that, entirely aside from the rules on hearsay and best evidence, Dr. Moore's testimony was properly excluded. Its manifest purpose was to reinforce the defendant's position that hospital access was "virtually unavailable". First, the testimony was irrelevant; the defendant's patient testified that she had not sought access to hospital services before she went to the clinic. Second, the testimony was largely cumulative; Dr. Belinsky and Dr. Soyster supplied essentially the same information. Third, under the rule in *Harris* v. *McRae, supra*, Dr. Moore's testimony was immaterial to determination of the constitutionality of the hospital requirement.

* * *

Supp 894 (D.Ind. 1980); *Akron Center for Reproduction Health, Inc., et al* v. *City of Akron*, 479 F. Supp. 1172, 1215 (N.D. Ohio 1979); *Wynn* v. *Scott*, 449 F.Supp. 1302 (N.S. Ill, 1979), *aff'd*, 559 F.2d 193 (7th Cir. 1979), *appeal dismissed for lack of jurisdiction*, 439 U.S. 8 (1979); *Livingston* v. *New Jersey State Board of Medical Examiners*, 402 A. 2d 967, *cert. denied*, 408 A.2d 800 (N.J. 1979).

While the Supreme Court has never considered a challenge to a second-trimester hospital requirement, the statute reviewed in *Planned Parenthood of Central Missouri* v. *Danforth, supra*, contained such a requirement. Arguably, one of the considerations which led the Court to strike down the proscription against the saline procedure was the knowledge that the law required physicians to perform the procedure in a hospital.

Finding no merit in the defendant's several assignments of error, we will affirm the judgment.

Affirmed.

APPENDIX B

Ruling Of Criminal Trial Judge On Validity Of Abortion Statute, *Commonwealth* v. *Simopoulos*, Crim. No. 30906 Tr. p. 69 (Va., Fairfax City Ct., Apr. 15, 1980)

"THE COURT: Mr. Lucas, I appreciate your argument. I am going to deny your motion.

I am certainly not going to go further than the Supreme Court, that I believe the Supreme Court has gone at this point.

There is in this community the availability of Fairfax Hospital which certainly does these second trimester abortions. Their facilities are available to the Defendant in this case.

Furthermore, from the evidence I have heard, I frankly believe that the regulations that the Virginia Legislature has imposed on second trimester abortions are reasonably related to maternal health and are not unconstitutional in any way.

* * *

So, I will deny your motion."

Statements Of Prosecutor And Court At Hearing On Sentencing, *Commonwealth* v. *Simopoulos*, Crim. No. 30906 Tr. pp. 15, 18-21 (Va., Fairfax Cty Ct., Apr. 18, 1980)

. . . "[Prosecutor:] This Defendant did not accept the way Virginia said how to do it. Current wisdom is for victimless crimes is the Defendant is somewhat in the situation of somebody illegallly in possession of gambling slips or illegally in possession of obscene literature.

He's engaged in victimless activity according to the law. Current wisdom is that community service makes sense in these kinds of cases.

It would be the recommendation of the Commonwealth that he receive a suspended penitentiary sentence and the Court order him to perform some type of community service."

* * *

[Tr. 15].

[Tr. 18] "THE COURT: Well, Doctor, I want you to understand what I've considered and why I'm going to sentence you.

So far as keeping your medical license I really have no control over that at all. That's up to the other doctors on the Medical Board, and I'm taking no position whatsoever on that.

If they determine that you should keep your license then that would be fine with me. I'm not refusing your counsels request to suspend imposition of sentence because I want them to take your license that's up to the medical profession.

Insofar as your defense of not knowing the law maybe that's true I have a very, very difficult time believing it, that a man who is in fact in the abortion business doesn't know what the [Tr. 19] laws are concerning his profession.

There are only four or five of them in Virginia.

Insofar as being sentenced for killing a baby or killing a person or things of that nature which have been brought out I'm certainly not sentencing you for that, regardless of whether I think it's wrong to do it or right to do it makes no difference.

The Supreme Court and the Virginia Legislature have said it's okay, and I accept that, and I look at your case as really one where you were doing that which you had a legal right to do, but you weren't following what I consider legitimate regulations handed down by the legislature of Virginia.

I recognize the fact that your clinic has been described by the witnesses here as being certainly more than adequate. I'm not sure that everyone performing these procedures would have that sort of clinic, and I think that the State of Virginia has a legitimate interest in providing for the health of these patients, and requiring [Tr. 20] that it be done in a hospital, and I'm not going to make a big speech to you. I'm just trying to tell you the things I'm considering.

Our society has really accorded to the medical profession a tremendous amount of prestige, a lot of privilege, a lot of tremendous financial reward, and I feel personally that with that goes a certain or equal amount, probably of responsibility and accountability.

I'm looking at the fact that you have no prior record. I believe you are a good family man. You have four young children. I believe you're a good church-man, Saint Catherines as the Father testified to.

Probably, most impressive to me personally is the fact that you're a boy who came from illiterate parents in the mountains of Macedonia, and got through the University of Athens Medical School. For my understanding of the particular achievement it's probably equivalent to a share-cropper's kid from South Carolina in the 30's getting through Harvard. It's something to be proud of.

When I recessed the other day I really [Tr. 21] considered community service as the Commonwealth has recommended, and I reject that idea.

I'm not going to — I don't think community service is appropriate in this case. I can't see you out along the highway picking up tin cans.

So far as some sort of medical service I frankly feel that some people might object to being treated by you, and I'm not going to order that either. You can do that on your own.

I do sentence you to two years in the penitentiary. I suspend the entire two years conditioned on your serving 30 days in the Fairfax County Jail, that time to be served on weekends Saturday at 8:00 a.m. to Sunday 8:00 p.m., and place you on two years inactive probation.

Do you have any motions?

MR. LUCAS: Do you suspend the jail time pending appeal, Your Honor?

THE COURT: Well, I will suspend execution of this sentence pending any appeals and will continue the present bond that the Doctor has. Thank you very much."

APPENDIX C

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

VIRGINIA

COMMONWEALTH OF VIRGINIA

v.

CHRIS SIMOPOULOS

Indictment — Abortion

Cr. #30906

This 15th day of April, 1980, came the Commonwealth by her Attorney, and the Defendant, CHRIS SIMOPOULOS, who stands indicted for a felony, to-wit: abortion, appeared agreeably in accordance with his recognizance of bail; also appeared Gene Hines and Roy Lucas, Counsel for the Defendant.

Whereupon, the Court Reporter was sworn.

Whereupon, the Court proceeded to hear further evidence and argument on the Defendant's motion to dismiss the indictment returned herein, which motion the Court denied.

Whereupon, the Defendant was arraigned upon the indictment returned herein, to which the Defendant, in person, entered a plea of not guilty and in person and in writing signed by him, waived his right to a trial by jury, to which the Attorney for the Commonwealth consented and the Court concurred.

Whereupon, the Court heard opening statements of the Attorney for the Commonwealth and Counsel for the Defendant reserved opening statements.

Whereupon, the Court heard all of the evidence presented on behalf of the Commonwealth and at the conclusion of the

evidence presented, Counsel for the Defendant moved the Court to strike the evidence presented on behalf of the Commonwealth, which motion the Court denied.

Whereupon, Counsel for the Defendant renewed all of the Defendant's previous motions, which motions the Court denied.

And it appearing to the Court that this case could not be concluded at a reasonable hour, hereby continued this case to Wednesday, April 16, 1980 at ten o'clock a.m.

And the Defendant is hereby continued on bond.

/s/ F. BRUCE BACH
F. Bruce Bach

A COPY TESTE:
JAMES E. HOOFNAGLE,
Clerk
By: KATHERYN SWART
Katheryn Swart
Deputy Clerk

APPENDIX D

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

VIRGINIA

COMMONWEALTH OF VIRGINIA

v.

CHRIS SIMOPOULOS

Indictment — Abortion

Cr. #30906

This 16th day of April, 1980, came the Commonwealth by her Attorney, and the Defendant, CHRIS SIMOPOULOS, who stands indicted for a felony, to-wit: abortion, appeared agreeably in accordance with his recognizance of bail; also appeared Gene Hines and Roy Lucas, Counsel for the Defendant.

Whereupon, the Court Reporter was sworn.

Whereupon, the Court heard all of the evidence presented on behalf of the Defendant and at the conclusion of the evidence presented, Counsel for the Defendant renewed all of the Defendant previous motions, which motions the Court denied.

Whereupon, the Court heard closing arguments of Counsel and in consideration of the evidence heard and argument of Counsel the Court doth now find the Defendant, CHRIS SIMOPOULOS, guilty of abortion, as charged in the indictment returned herein.

And this case is hereby continued to the 18th day of April, 1980 at nine o'clock a.m. for imposition of sentence.

And the Defendant is hereby continued on bond.

/s/ F. BRUCE BACH
F. Bruce Bach
Judge Bach

A COPY TESTE:
JAMES E. HOOFNAGLE,
Clerk

By: KATHERYN SWART
Katheryn Swart
Deputy Clerk

APPENDIX E: JUDGMENT OF VIRGINIA SUPREME COURT

IN THE SUPREME COURT OF VIRGINIA HELD AT THE SUPREME COURT BUILDING IN THE CITY OF RICHMOND ON FRIDAY THE 24TH DAY OF APRIL, 1981.

Record No. 801107
Circuit Court No. C-30906

VIRGINIA

CHRIS SIMOPOULOS, *Appellant,*

against

COMMONWEALTH OF VIRGINIA, *Appellee.*

Upon An Appeal From A Judgment Rendered By The Circuit Court Of Fairfax County On The 18th Day Of April, 1980.

For reasons stated in writing and filed with the record, the court is of opinion that there is no error in the judgment appealed from. Accordingly, the judment is affirmed. The appellant shall pay to the Commonwealth of Virginia thirty dollars damages and the costs expended herein.

This order shall be forthwith certified to the said circuit court.

A COPY,

TESTE:

/s/ ALLEN L. LUCY
Allen L. Lucy
Clerk

TESTE:
/s/ ALLEN L. LUCY
Allen L. Lucy
Clerk

APPENDIX F

IN THE SUPREME COURT OF VIRGINIA

Record No. 801107
Circuit Court No. C-30906

CHRIS SIMOPOULOS, M.D., *Appellant,*
v.
COMMONWEALTH OF VIRGINIA, *Appellee.*

Notice Of Appeal

Chris Simopoulos, M.D., pursuant to 28 U.S.C. sec. 1257(2), (3), and U.S. Supreme Court Rules 10-12, hereby notices his appeal to the Supreme Court of the United States from the final judgment of the Supreme Court of Virginia rendered April 24, 1981.

Respectfully submitted:

ROY LUCAS & ASSOCIATES, P.C.
Suite 424
1055 Thomas Jefferson St., N.W.
Washington, D.C. 20007
(202) 338-6955

ROY LUCAS
Roy Lucas
Attorneys For Appellant

[filed July 6, 1981]

BROWDER, RUSSELL,
MORRIS & BUTCHER
1200 Ross Building
Richmond, Virginia 23219
(804) 771-9300
By: _____
John H. Obrion, Jr.
Dated: July 2, 1981

Joint Appendix

No. 81-185

Supreme Ct.
FILED
AUG 9 1982
ALEXANDER L. STEVAS,
CLERK

In The

Supreme Court of the United States

October Term, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Appellant,

vs.

COMMONWEALTH OF VIRGINIA,
Appellee.

Appeal from the Supreme Court of Virginia

JOINT APPENDIX

ROY LUCAS
LUCAS & ASSOCIATES, P.C.
Three Ten Constitution Avenue, N.E.
Washington, D.C. 20002
(202) 543-5115

WILLIAM P. MARSHALL
1515 Hague Avenue
St. Paul, Minnesota 55104
(612) 644-5145

JOHN H. OBRION
BROWDER, RUSSELL, LITTLE,
MORRIS & BUTCHER
1200 Ross Building
Richmond, Virginia 23219
(804) 771-9300

Attorneys for Appellant

GERALD L. BAILES
Attorney General
WILLIAM G. BROADDUS
Chief Deputy Attorney General
THOMAS D. BAGWELL
Assistant Attorney General
JULIE KREBS-MARKRICH
Assistant Attorney General
Attorneys for Appellee
Supreme Court Building
Richmond, Virginia 23219
(804) 786-2071

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RELEVANT DOCKET ENTRIES OF CIRCUIT COURT

COMMONWEALTH OF VIRGINIA

In the Circuit Court of
the County of Fairfax

COMMONWEALTH OF VIRGINIA

vs. Criminal No. 30906

CHRIS SIMOPOLOUS (sic)

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Opinion of the Supreme Court of Virginia, filed April 24, 1981.....J.S. 1a

VIRGINIA:

IN THE CIRCUIT COURT
OF FAIRFAX COUNTY

COMMONWEALTH OF VIRGINIA

vs.

CHRIS SIMOPOULOS, M.D.

MOTION TO DISMISS INDICTMENT

Defendant Chris Simopoulos, M.D., respectfully moves this Court to dismiss the indictment and in support of this motion states:

1. The indictment fails to state a valid offense under VA. CODE Section 18.2-71. The requirement that abortions in the second trimester of pregnancy be performed in a hospital, VA. CODE Section 18.2-73, on its face and as applied violates the Due Process Clause of the Fourteenth Amendment and corresponding provisions of the

Virginia Constitution. Section 18.2-73 is also unconstitutionally vague and overbroad.

2. The indictment uses the inflammatory term "unborn child." Such terminology is inconsistent with that used by the United States Supreme Court and the medical profession. There is no justification for the Commonwealth's using this term. It is not descriptive or in Supreme Court decisions. The Commonwealth is using the term for only one reason - to inflame and prejudice the jury against Dr. Simopoulos.

3. The statute does not apply to Dr. Simopoulos. Viewing the Commonwealth's evidence most favorably, the evidence fails to show that Dr. Simopoulos "performed" an abortion. The Commonwealth's evidence alleges only that the patient was instilled

with saline solution in the defendant's facility and subsequently aborted outside his control. Indeed, the evidence suggests that the patient chose to take herself out of Dr. Simopoulos' control and that he did not know where she was going. Dr. Simopoulos' alleged conduct does not constitute performance of an abortion by any definition. He cannot be fairly charged with violation of Section 18.2-73 and Section 18.2-71, particularly where he gave her follow-up instructions directing her to go to a hospital.

In light of the foregoing, the indictment against Dr. Simopoulos must be dismissed.

* * * * * * *

VIRGINIA

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

COMMONWEALTH OF VIRGINIA

-v-

CHRIS SIMOPOULOS,

Defendant.

Criminal Docket No. 30906

Fairfax, Virginia

Monday, April 14, 1980

The above-entitled cause came on for motions, before THE HONORABLE F. BRUCE BACH, Judge, in and for the Circuit Court of Fairfax County, Virginia,

* * * * * * *

[3] MR. LUCAS: Your Honor, the first

motion that we will go forward on this morning will be the Motion to [4] Dismiss the Indictment. We have filed a Motion in Limine in timely fashion with the Court, have filed a memorandum of law in support of a Motion to Dismiss the Indictment and included in that a memorandum in support of the Motion in Limine to exclude any inflammatory language.

We have provided to the Court the memorandum. I have with me for the Court extra copies of the principal U.S. Supreme Court case that we are relying on as well as a subsidiary U.S. Supreme Court case and a decision from a federal district court in Louisiana which invalidated the same type of law, along with many

other provisions.

* * * * * * *

[5] After the 1973 Roe v. Wade decision, for two years there was no additional restriction in the Commonwealth. I think it was in 1975 when this particular statute was developed which requires by its own terminology that second trimester abortions be, quote, performed in a hospital.

It is our contention that that restriction in practice and on its face has worked out to impose an unconstitutional burden upon physicians and upon patients. The evidence in the case on this motion will show that very few hospitals, if any, permit second trimester abortions.

So that the state restriction in effect sharply precludes access to abortion, sharply restricts a physician's ability to perform abortions, and in particular with minors the hospitals require parental consent. So that if a minor goes to a hospital for all aspects of an abortion, then she will have to waive a fundamental constitutional right.

The Supreme Court in its decision which we handed to the Court, Planned Parenthood v. Danforth, [6] eliminated the parental consent requirement in the state by requiring abortions to be done in hospitals has in effect unconstitutionally reinstated it.

The evidence will also show, of

course, that the second trimester hospital requirement is not only burdensome in those respects but is medically unnecessary because second trimester abortions can be quite safely done on an outpatient basis as they were during hiatus before the 1975 law was passed.

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There is no legislative history on the statute. There is no reason to believe that the state ascertained any compelling basis or any health basis for the purpose of validating the statute, and I will just refer the Court in particular to the page 810 in 49 Lawyers Edition in Planned Parenthood v. Danforth [7] where the Supreme Court concluded that saline abortion, which is involved in this case, is safer with respect to

maternal mortality than even continuation of the pregnancy until normal childbirth.

That ties in with the language the Supreme Court used back in 1973 where, first of all, the court said that in the first trimester the state could not interfere or regulate facilities for provision of abortion services. In the second trimester the state could only have regulations which were reasonably related to maternal health.

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[8] DR. HAROLD SCHULMAN

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[9] A. I am an obstetrician/gynecologist and I am the professor and chairman of the Department of Obstetrics and Gynecology at

the Albert Einstein College of Medicine in New York City.

Q. Are you in charge of more than one hospital [10] department in OB/GYN?

A. Yes. As the chairman of the department, I am responsible for four hospitals.

Q. And could you give us a brief summary of the national organizations in the OB/GYN field that you belong to and any positions you have held with them.

A. Well, I am a member of the American College of OB/GYN, the American Association of Obstetrics and Gynecology, the Society for Gynecological Investigation, the Association of Professors of Gynecology and Obstetrics, the New York Obstetrician Society, Planned Parenthood Association,

the Association for Maternal and Fetal Health. That's a few of them.

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[11] Q. Have you been actively involved in teaching postgraduate students in obstetrics and gynecology?

A. Yes.

Q. Does the field of obstetrics and gynecology cover saline abortion procedures?

A. Yes, it does.

Q. What other areas in general does the field of obstetrics and gynecology encompass?

A. Well, the major fields include obstetrics which would include normal and high risk obstetrics, gynecology which

then covers all medical and surgical conditions related to female reproduction and a special subdivision such as fertility, sexual therapy, endocrinology, cancer.

Q. Do you have any board certifications and, if so, could you describe those and what field they are in.

A. Yes, I am boarded in the American Board of Obstetrics and Gynecology and I have a subspecialty board in maternal and fetal medicine which is high risk obstetrics.

Q. And to what extent are you involved, say, annually in the delivery or the supervision of the [12] delivery of infants at the hospitals you are in charge of?

A. The hospitals which I direct deliver approximately ten thousand babies

per year and has approximately one hundred and twenty inpatient gynecologic beds, and we see in the range of fiteen hundred women per week in outpatient facilities.

Q. Are those hospitals also involved in delivering services to women with unplanned pregnancies who wish to abort those pregnancies?

A. Yes.

Q. Did you in the early '70s write a book pertaining to the subject of abortion techniques?

A. Yes, I did.

Q. And did that cover first and second trimester?

A. Yes, it did.

Q. Did you also publish a study on outpatient second trimester saline

abortions?

A. Yes, I did.

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[14] Now, the way the procedure is done is really relatively simple. The abdomen is washed and cleansed and then a small injection is made into the skin to numb the skin so it doesn't hurt. The injection is carried down through the abdominal wall.

Once the area is numb, a needle is inserted directly into this fluid space, the amniotic fluid. When it is evident that there is a clear flow of this fluid then it is really a simple matter of injecting a salt solution into this fluid cavity.

Now, it can be injected in or it can

be dripped in. There's certain things. The woman must be awake when it is done so that because one of the hazards of the procedure is if the salt is injected into the wrong place.

For example, if it was injected into tissue or if it was erroneously injected into the abdominal cavity, it could cause injury and it causes considerable pain. So you want the woman awake when the procedure is carried out.

The procedure if it is carried out normally and uneventfully is entirely painless, and once the [15] specified amount of salt solution is placed into the amniotic fluid, the needle then is simply removed and the woman is observed for a

period of time for any kinds of side effects.

Q. Well, Dr. Schulman, can that injection or instillation be done outside of a hospital?

A. Yes.

Q. And have you had an opportunity to visit Dr. Simopoulos' clinical facility?

A. Yes, I have.

Q. And was his facility a facility that was adequate for that injection procedure?

A. Yes, it is.

* * * * * * *

[16] Q. What equipment did you see in Dr. Simopoulos' office?

A. The treatment rooms which I saw were really equipped like operating rooms. There was excellent lighting and there was wall outlets for oxygen, the administration of anaesthetics. There were suction machines, it was equipped for resuscitation and in case [17] of cardiac or respiratory arrest. It was really equipped more like an operating room than a treatment room.

Q. Did it have any kind of heart monitors in it?

A. Yes, it did.

Q. Did it have something called a defibrillator and could you explain what that is and what it is used for?

A. Yes, that was part of the resuscitation equipment. If someone were to

have an irregular heart action and a normal heart action was necessary, this is an electrical shock so to speak applied to the heart which reestablishes a normal heart action.

Q. Did it have an EKG machine in there and can you tell us what it does?

A. Yes, it did. Well, that is for the measurement of the electrocardiogram, the electrical activity of the heart.

Q. After saline solution has been injected into the patient's uterus, does that constitute an abortion or do you have to have expulsion of the fetus for that?

A. No. The mere injection is not considered to [18] be the abortion. Abortion is defined as the expulsion of a fetus before the twentieth week of

pregnancy or weighing less than five hundred grams.

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BY MR. LUCAS:

Q. Let me show you what's marked as Defendant's Exhibit 2 and ask you if that's the accepted OB/GYN definition of abortion.

A. Yes.

Q. And does that include expulsion of the fetus?

A. Yes.

Q. So, at the time the saline solution is injected into the patient, do you have an abortion yet?

A. No.

Q. Does the saline solution always cause the fetus subsequently to be aborted?

A. No.

Q. Does it fail in a significant number of cases?

A. Once the saline is injected, the average time for expulsion of the fetus is thirty-two hours. However, approximately seven to ten percent will not go into labor [19] or abort at all.

Q. Can the patient go home after the saline procedure has been done and await the abortion at home?

A. Yes, with proper instructions.

* * * * * * *

Q. Have you had an opportunity to look at what I will mark as Defendant's

Exhibit 3 entitled on the top, "Post Injection Information"?

A. Uh-huh.

Q. Have you had an opportunity to see this?

A. Yes.

Q. And putting aside a few typographical errors in those, are those in your opinion adequate postoperative instructions?

A. Yes, they are.

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[20] Q. How many patients were involved in the study that you did on outpatient saline?

A. Well, I think the last time reported it was 670 odd women. The original study was 350 odd women I believe.

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Q. First of all, the study that you conducted, were those patients injected in a treatment room?

A. Yes.

Q. Was the treatment room equivalent or similar to Dr. Simopoulos' facility?

A. Yes. Yes.

Q. Similar to or equivalent to?

A. Well, I would say it was less equipped than his treatment rooms.

Q. And did the patients in your study go home after the injection?

A. Yes, they did.

Q. And what proportion of those patients aborted at home?

[21] A. A surprisingly large number. As I recall, it was close to sixty-five percent.

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A. I think ninety-five percent of the women were sixteen to twenty-two weeks.

Q. And what were your findings as to the comparative complication rates between the patients who had been done in that range on a fully inpatient basis and patients who were done on an outpatient basis?

A. We felt that our results were equal to or [22] better than those that had been previously reported.

Q. About what proportion of the patients even had to have medication for pain?

A. Less than twenty percent.

Q. In that particular study, how fast did labor take place with the

patients?

A. Well, we broke it down into one day, one to three days or later. As I recall, eighty percent of the women aborted within the first three days and the average period of time was in the thirty-two to thirty-six hour range.

Q. Were there any disadvantages from having medical attendants with the patients at the time they aborted?

A. We felt there were potential disadvantages, those which we had observed prior to initiating this study. In the first place, in a general hospital environment the woman was exposed to people who were not supportive of her, were frequently critical of her. She, therefore, was the recipient of unfavorable

remarks or even apathy by the people who were assigned to help her.

Secondly, house staff or physicians who may be present. House physicians that may be present when [23] the abortion process started had a tendency to attempt to expedite that.

* * * * * * *

[24] Q. Do you agree or disagree with the U.S. Supreme Court statement that saline abortion, quote, is safer with respect to maternal mortality than even continuation of the pregnancy until normal childbirth, close quote?

A. Yes, I do.

* * * * * * *

[29] Q. Could you state to us, Dr. Schulman, any benefits that you are aware

of to patients, to physicians or to hospitals of permitting the injection of saline on an outpatient basis?

A. The period of hospitalization is shorter and that period would be limited to the time when she needed to be observed.

Q. Are there any benefits that depend on the availability of hospital beds?

A. If beds are at a premium, that would be an important factor.

Q. Is there a proportion of these patients who require no hospitalization whatsoever?

A. Yes.

Q. In the national organizations that you are involved in, do Virginia doctors participate in those organizations as far as you know?

A. Yes.

Q. Do Virginia doctors take the same board exams [30] that physicians from other places do?

A. Yes, they do.

Q. Do you have any reason to believe that saline solution is made in any different way in Virginia than it is in other places or are there national suppliers for these things?

A. There are national suppliers of this solution.

* * * * * * *

[32] Q. Is it medically possible after saline is injected in a patient for there to be some other factor that causes the patient to abort?

A. Yes.

Q. Could some drugs or medications cause the patient to abort under those circumstances?

A. Yes, they could.

* * * * * * *

CROSS-EXAMINATION

BY MR. HORAN:

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[33] Now, the saline procedure according to your testimony, the normal purpose of it is to induce abortion; isn't that true?

A. Yes.

Q. I mean, does anybody do a saline solution into the amniotic sac for any other reason?

A. No.

Q. So, when a doctor goes in and puts the needle in the sac, he wants that unborn child to be expelled in effect.

A. Correct.

* * * * * * *

[36] Q. Doctor, will you explain what is the pathology of death of that unborn child?

What does the saline do that causes its death?

A. The saline is what we call a hypertonic solution and that means when it comes in contact with body tissues it draws the water out of those tissues. So, we think the way the saline, hypertonic saline, works is by drawing the water out of the placenta and [37] the placenta is the organ which sustains the functions within the fetus.

We think by destroying the placenta essentially and its function that

precipitates labor.

Q. Does that fetus cease to -- does blood cease to circulate or something like that in the fetus while it is still in the uterus?

A. Yes.

Q. So, in effect the fetus, for want of a better word, dies while it is still in and then gets expelled by the uterus?

A. That's correct.

Q. And that is so because the uterus generally will reject a foreign body; isn't that it?

A. That is partially true, but it is primarily because the placenta has lost its ability to sustain the pregnancy. The placenta or afterbirth is the organ that keeps a woman from expelling the products

of conception.

Q. For all intents and purposes, if the saline is done correctly, if the procedure is done correctly, the die is cast and that fetus will be expelled.

A. Yes.

Q. In the ten percent of the time where you say [38] it is not expelled it is because something went wrong with the procedure.

A. Not necessarily went wrong technically, it just works nine out of ten times. Then something additional would have to be done to produce the abortion process.

Q. But in theory if the procedure is followed that you have just outlined here and the physician does it the way

you outlined it here, then that fetus will be expelled and the abortion will be complete.

A. Sooner or later for the most part.

Q. Now, you said that the average time for expulsion is thirty-two hours?

A. Yes, sir.

Q. Which means you can have some, I think in your testimony, go up to as much as three days?

A. Yes.

Q. As a matter of fact, eighty percent I think you said get aborted within three days?

A. Yes.

Q. But the normal would be a day and a half or so?

A. Yes.

[39] Q. In the study that you talked about

with the three hundred and some patients and the six hundred and some patients, where was that study done?

A. In New York City in the Bronx Municipal Hospital.

Q. And you were examining the women who were injected within that hospital?

A. Within an outpatient facility in that hospital.

* * * * * * *

[40] Q. Now, I believe you testified that one of the things you should do is have a waiting period between the time the saline is injected and the time the patient leaves the hospital or leaves the clinic.

A. Yes.

Q. What is the reason for the waiting period?

A. To see if there are any unusual reactions to the instillation of the solution.

Q. Are there times some unusual reactions?

A. Yes. The reactions can be for some unexplained reason. A disproportionate amount of the salt solution somehow gets into her bloodstream and she will give certain symptoms of thirst or headache, nausea, vomiting and on rare occasions the uterus will abruptly begin to swell.

[41] Q. Is there some evidence in certain cases that the saline interferes with the clotting mechanism in the blood?

A. Yes. It can occur but that's a problem for the most part that only appears when she goes into labor. It becomes a clinical problem once she goes into labor.

Q. And as a matter of fact, when she goes into that labor it can be a very serious problem, the bleeding.

A. Yes.

Q. As a matter of fact, there are a number of reported cases of death because of the total evacuation of blood without any quick ability to do something about it.

A. There are some.

Q. Did you see any blood transfusion equipment in Dr. Simopoulos' office?

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Other than the blood, the heavy bleeding at the time of delivery, are there some other problems connected with delivery, potential problems connected with delivery in the case of a saline abortion?

A. It could be the same problems of

any delivery [42] potentially.

Q. Now, does the age of the fetus make a difference?

A. In terms of what?

Q. Delivery.

A. There are differences, yes.

Q. In other words, there is a difference between delivery of a thirteen week fetus and delivery of a twenty-two week fetus?

A. There would be.

Q. Because a child is bigger, among other things.

A. Well, the problem actually is more with the afterbirth than with the fetus. The afterbirth actually tends to pass completely more frequently in the later pregnancies than in the earlier ones,

so it turns out to be the opposite.

Q. Is saline done at all stages of pregnancy?

A. It has been but I think most people now are restricting it to sixteen weeks or more period and not doing it in the earlier pregnancies because of the problem with the placenta that I mentioned.

Q. And that is relatively recent?

A. No, I think within the past four or five [43] years.

Q. Prior to that time they were doing salines at all stages?

A. Well, thirteen weeks or later. There has to be a pocket of fluid present that you can reliably get into to inject the solution.

Q. And the sufficiency of the fluid

comes along some time along the thirteen week mark?

A. Thirteen weeks or later, yes.

Q. And the thirteen week mark is generally accepted as the beginning point of the second trimester?

A. Yes.

Q. And the second trimester runs till when?

A. Well, in theory it runs till the twenty-seventh week of pregnancy.

Q. So, saline is generally used from thirteen to twenty-seven weeks?

A. No. Most state laws say that one cannot go beyond twenty-four weeks in inducing an abortion.

Q. Is there some indication that the D&E method is superior to the saline

method in the second trimester?

A. At least up to sixteen weeks I think it is.

Q. Did you testify down in a Louisiana case on [44] this point?

A. No.

Q. Did you agree with the claim in that case that the D&E method is far superior to anything else in the second trimester?

A. Well, I don't know what was said in that trial, but there's been a number of publications out of the CDC, the Communicable Diseases Center, Abortion Surveillance Unit in Atlanta which I think is demonstrating that.

Q. Tell the Judge what the D&E method is.

A. The D&E stands for dilatation and evacuation and it means that dilating the cervix is used which is different than that which is ordinarily done. Ordinarily when one dilates the cervix you use a series of instruments, each one having a slightly larger diameter which then mechanically dilates the cervix.

In a D&E, substances are used which are called laminaria which is actually a form of seaweed and they are hydrophobic meaning -- hydrophilic meaning they absorb water and they look like little cigars. You insert them into the cervix and then the cervix gradually swells over a four to twelve hour period so a larger and [45] perhaps safer dilation can be carried out.

After that point, when the cervix is wide open, then the fetal tissue can be mechanically or surgically removed rather than an injection process and labor carried out.

Q. And that's gradually becoming the preferred method?

A. I think it is the most widely used method up to sixteen weeks, but from that point on the later pregnancies I think the majority of people in the country are still using injection techniques simply because it may require more training and it is probably more acceptable to most physicians.

Q. Is the D&E method considered safer than saline?

A. It depends upon which way you look at it. I think in terms of certain kinds of complications such as hemorrhage or infection there are more with saline, but more drastic complications may occur with the D&E such as perforating the uterus and then requiring major surgery. So, it is a questionable trade off at this point.

Q. Well, of course, perforating the uterus, [46] that would be a mistake by the physician, wouldn't it?

A. Yes, it is but no matter how skilled you are, when you are dealing with a uterus that soft and that big you are going to perforate.

Q. But there is no question that would be as a result of a mistake?

A. No, it is not a mistake. It is a technical hazard of carrying out that operation.

Q. There is no question, though, that the critical part and most of the potential injury which occurs here, most of the potential problem that occurs here, the critical part is the delivery portion?

A. Yes.

Q. Whether you are doing saline or D&E, it is the actual delivery portion, the removal portion, that is the dangerous and critical point.

A. Correct.

Q. When you are doing D&E, you have got a physician standing there doing that.

A. Yes.

Q. When you are doing saline, a phy-

sician may or may not be there.

A. Most of the time not there.

[47] Q. That's right. Most of the time, as a matter of fact, they are being delivered by some woman sitting in her home.

A. I can't answer that.

Q. Well, you don't object to that being done?

A. I object to the way it was stated.

Q. Well, you don't have any problem -- in your own theories on this matter you don't have any problem with injecting the woman with saline and letting her go to the motel next door and deliver it? You don't have any problem with that, do you?

A. If she is properly instructed.

Q. If she is properly instructed.

And you feel that the risk of heavy bleeding at time of delivery is a risk worth taking?

A. I think the woman should go to the hospital when she goes into labor. Many women, however, do not and have not because the process has occurred so rapidly. That's a choice that they make.

Q. But you think when they go into labor they should go into a hospital?

A. I think that's what they should be instructed to do.

[48] Q. And that's because of the danger that's inherent in this whole process.

A. Yes.

* * * * * * *

[72] Q. Detective, would you state your name and your position for the record.

A. My name is James R. Dooley, Jr. I am an investigator with the Fairfax County Police Department.

Q. Detective Dooley, directing your attention back to November of 1979, did there come a time when you had a reason to respond to a motel in Fairfax, Virginia, with respect to this case?

A. Yes, sir.

Q. What was the nature of the communication that caused you to respond?

A. It was related to me that an infant or fetus had been found in a trash can in a motel room and my presence was requested by the uniformed officer on the scene.

Q. Was that Officer Boyle?

A. That's correct.

Q. All right. And Detective Dooley, did you initially think that you were responding to a possible death of an infant at that time?

A. Yes, I did.

* * * * * * *

[73] Q. Well, were there a number of items that were [74] found in the motel room relating to Dr. Simopoulos?

A. There was one item that I found in the motel room while I was there.

Q. Okay. And was that a prescription for Percodan?

A. That's correct.

Q. Okay. Now, and that prescription had medication in it?

A. Yeah. Let me clarify that. I did not find a prescription, I found the prescription bottle.

Q. Okay. And did the prescription bottle have Dr. Simopoulos' name on it?

A. It did.

Q. Okay. So, you could assume from the bottle itself that he was the prescribing physician?

A. That's correct.

Q. All right. And was there a set of directions in the room to Patty McDonald to advise her what to do with respect to her pregnancy?

A. I did not discover I believe what you are speaking in reference to until later that afternoon.

Q. All right. Where was it discovered later that afternoon?

[75] A. In the trash container that also had the fetus in it.

Q. Okay. There is no question that those directions were in the container that contained the fetus in the motel room?

A. No, sir, there is no question.

Q. Okay. And those directions, did they contain on the bottom of those directions or someplace marked visibly thereon the name and telephone number of Dr. Simopoulos?

A. I believe so.

MR. HINES: Your Honor, I think you have an exhibit up there which is either 2 or 3 from the previous hearing.

BY MR. HINES:

Q. Detective, let me show you what's been marked already as Defendant's Exhibit

3 for purposes of motions. Can you identify that?

A. That appears to be a reproduction of the form that I found in the motel room.

Q. Very well. But again this form contained Dr. Simopoulos' name and telephone number, did it not?

A. That's correct.

[76] Q. Okay. So that was the second item that you found in the room that possibly suggested to you that Dr. Simopoulos might have been involved with Patricia McDonald in some fashion?

A. Yes, sir.

Q. Okay. Now, was there anything else in that room that identified Dr. Simopoulos' involvement in the case?

A. Not that I recall.

* * * * * * *

Q. Detective Dooley, is it not a fact -- When did you call Dr. Simopoulos?

A. I would have to guess the time to be approximately 3:00 o'clock, 3:15 in the afternoon.

Q. All right. Several hours after you had arrived at the motel?

A. (Nodding head.)

[77] Q. Now, besides Officer Boyle there were other officers at the motel room, were there not?

A. Yes, sir.

Q. Okay. And in addition was the Fairfax County medical examiner called to come to the motel room to examine the fetus at that time?

A. As a matter of routine where there is any death involved, we notify the Fairfax County medical examiner who is Dr. Cooper. It just so happened on that day that he was in the area and came by.

Q. He did?

A. Yes, sir.

Q. Were you there, were you present when Dr. Cooper examined the fetus at that time?

A. Yes, sir.

Q. Okay. Now, did he give an indication to you at that time as to the cause of the death of the fetus?

A. No, sir, I can't say that he gave me an estimate of the cause of death. No.

Q. All right. What did he give you?

A. He observed what was in the trash can. It was not removed from the trash can at that location. He observed that it did appear to be a fetus and ordered it [78] removed to the Fairfax County Hospital.

Q. All right. Now, did you accompany him to the Fairfax County Hospital for the autopsy examination of the fetus?

A. I transported the entire contents of that trash can to the hospital myself.

Q. Okay. Now, at the same time when you were at the motel, did you do any other investigation to ascertain the name of the occupant of the motel room?

A. Yes, sir.

Q. Okay. What exactly did you do?

A. Most of the information that I obtained at the motel had been obtained by Officer Boyle prior to my arrival. It was brought to my attention that there was a receipt bearing the name of the occupant of the room and that they had also taken a tag number from the vehicle that she was driving.

Q. Okay. So, you were able from that information to ascertain the identity of Patricia McDonald?

A. That's correct.

Q. Okay. And did you subsequently contact Patricia McDonald?

A. Yes, I did.

[79] Q. About what time did you contact her?

A. That would have been the following day. Again, I am just going to have to -- I believe it was probably around 11:00, 10:30, 11:00 o'clock in the morning.

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Q. Okay. And were you present when an autopsy was performed on the fetus?

A. Yes, I was.

Q. Okay. And who performed that?

A. Dr. Wiecking.

Q. All right. Now, approximately what time was that?

A. Here again, I can't be specific. I am just having to use recollection and I would recall some time 2:30 or 3:00 o'clock in the afternoon.

Q. All right. And have you seen a

copy of the [80] autopsy report that was prepared by Dr. Wiecking?

A. Yes, I have.

(The autopsy report referred to was marked Defendant's Exhibit No. 4 for identification.)

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Q. Okay. Now, but you can identify the autopsy report?

A. Yes, sir.

* * * * * * * *

[81] Q. Is the information in here a fair and accurate statement of the information that Dr. -- was it Weaker?

A. Wiecking.

Q. -- Wiecking gave you at the time the autopsy was performed?

A. Yes, sir.

Q. Okay. Now, what exactly did the doctor tell you as a result of the autopsy?

A. Dr. Wiecking did the autopsy. Also in attendance was Dr. Beyer and Dr. Cooper. It was their estimate at the completion of the autopsy as I recall, first they estimated the gestational age of the fetus to be twenty to twenty-two weeks. They provided me with the information on the length and weight which I don't [82] recall offhand.

After Dr. Wiecking had completed his study that afternoon, he informed me that one of the tests he had done to determine if there had been any life was to subject the lungs to water. His findings was that they did not float, indicating that there

was no air in the lungs.

Q. So, at that time you made a determination that there was no basis for charging anybody with death or homocide by --

A. No, I didn't.

Q. You did not?

A. No, sir.

Q. Okay. Did the doctor indicate to you, give you any indication of whether or not there was any basis for charging any other crime based on the medical happenings that he investigated?

A. No, sir.

Q. Okay. Now, what did you do to determine what you were going to do at this point as a follow-up on your investigation?

A. Are you talking about what did I

determine to do while I was at the hospital?

[83] Q. Yes.

A. After I left the hospital with what facts I had, I talked over the case with my supervisor who is Sergeant Wilson. We determined first off that we needed to find out and contact and talk with Patty McDonald number one because her health, having obviously had an abortion or delivered a fetus in a motel room, her health would be in question. If she needed medical attention, we were obligated to do what we could to see that she receives attention if necessary.

Secondly, with the facts that I had that afternoon, it was suggested by Sergeant Wilson that I contact the Commonwealth Attorney's Office in regard to the matter.

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[86] Q. When did you call Dr. Simopoulos, Detective?

A. While I was at the Fairfax Hospital and it was during the time that the autopsy was being performed.

Q. Okay. Now, you called Dr. Simopoulos' office, did you not?

A. That's correct.

Q. And Dr. Simopoulos was not available at that time, so you talked to one of the people in his office?

A. As I recall, it was a female voice that answered the phone. I identified myself and requested that Dr. Simopoulos call me at the number at the medical examiner's office as soon as possible. Approximately five minutes

later he returned my call.

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[87] Q. Okay. Now, shortly thereafter did Dr. Simopoulos in fact contact you?

A. That's correct.

* * * * * * * *

[90] Q. Detective, when you went to the motel room, you were investigating the possibility of a crime, were you not?

A. One would have to, yeah. Yes.

Q. One would have to assume that, is that not --

A. Yes, that is correct.

Q. At the outset one would have to assume that you thought that crime was a death, a homocide (sic).

A. To be quite honest with you, I didn't know what I had.

Q. All right. But there was a dead baby, to use Mr. Horan's word, in that room.

A. That's true.

Q. So there was a strong possibility if it was there left in a trash can that somebody might have been concealing something. Is that a strong possibility?

A. That's true.

* * * * * * * *

[92] Q. All right. Did it occur to you that Dr. Simopoulos might be impressed or somewhat more encouraged to respond to you because you were calling him from the medical examiner's office and he is a doctor?

[93] A. No, that thought never occurred to me.

Q. All right. He did respond to you

in a short period of time, did he not?

A. Yes, sir.

Q. Okay. Now, at the time he responded to you you identified who you were?

A. Yes, I did.

Q. Okay. Did you advise him of any rights at that time?

A. No, sir, I did not.

* * * * * * *

As a matter of fact. Dr. Simopoulos wasn't advised until seventeen days after that on the 29th of his rights for the first time.

A. Whatever the day of his arrest was, the 29th.

Q. All right. So for seventeen days after the time you contacted him, he was

never advised of his rights?

[94] A. Correct.

Q. Okay. Now, at the time that you talked to him over the telephone, did you tell him that you were investigating the commission of a crime?

A. No, I did not.

Q. Okay. As a matter of fact, what you told him was you wanted to know whether or not he had prescribed Percodan for Patty McDonald; is that a fact?

A. Yes, sir.

* * * * * * * *

[95] Q. Okay. And then you went on and asked him further questions?

A. Yes, sir.

Q. What else did you ask him?

A. In asking him questions, as I

recall asking him did he prescribe the Percodan, and his response was yes, eight or so. I asked for what purpose, and he said for abdominal pain. I said, well, was Patricia McDonald a patient of yours. You know, had you seen her, did you see her.

He acknowledged that he had. I said, for what purpose was she being treated. His response to that question was that he had done an abortion.

Q. Well, Detective, if you had called to find out whether or not the prescription was a faulty prescription, you had your answer as a result of the [96] first question when he told you that he had prescribed it, didn't you?

He said, yes, I prescribed it, did he not?

A. Yes, he did.

Q. Why did you not terminate your conversation at that point if that was your purpose for calling?

A. Just pure logic on my part that if he prescribed it I would want to know why he prescribed it.

Q. Well, could that have led to a further crime?

A. It is possible, yes.

Q. And that crime, could it have been possibly something that Dr. Simopoulos did; is that not right?

A. Correct.

Q. So at that point in time when you were questioning, the subsequent questions related to something that could have resulted in Dr. Simopoulos being charged; is

that not a fact?

A. That is true.

Q. Okay.

A. What you are saying is true.

Q. And yet you didn't advise him of his rights after the first question when he answered yes and you knew he prescribed it and got your answer with respect [97] to the possibility of a forged prescription.

You didn't stop then and advise him that he might be arrested or that maybe he might want to consult with a lawyer, did you not?

A. No sir.

Q. And you didn't tell him that he might be the subject of investigation at that time.

A. No, sir.

Q. And you didn't tell him that you were going to go get a search warrant for his business premises, did you?

A. No, sir.

* * * * * * * *

[99] A. I can't tell you what Investigator Warner had knowledge of and what he didn't.

Q. Well, he wasn't at the motel room with you?

A. No, sir.

[100]Q. And he wasn't present at the autopsy?

A. No, he wasn't.

Q. And it was you that contacted Dr. Simopoulos?

A. That is correct.

Q. It was you that contacted Patricia McDonald?

A. Correct.

Q. So, all the facts that the magistrate relied on in issuing a warrant in this case were of your personal knowledge and possession, those facts, were they not?

A. Yes, sir.

* * * * * * *

Q. All right. Now, you embodied in this affidavit the statements and admissions that Dr. Simopoulos made to you on the telephone, did you not?

A. They are contained in there, that is correct.

* * * * * * *

[106]Q. Okay. How about as a result of executing the search warrant was his clinic photographed?

A. Yes, sir.

Q. Okay. And who was that done by?

A. I believe Lieutenant King with the Falls Church Police was the one who took those photographs.

Q. Okay. How many photographs were taken?

A. I would imagine several rolls of pictures were taken.

Q. Can you give us an idea of how many pictures we are talking about, fifty or sixty pictures?

A. My estimate would be maybe twenty-five or thirty. There may be more.

* * * * * * *

[107]Q. Detective, to back up a second. I believe you testified that at some point along the line you called Patricia McDonald after you had ascertained her name because of the registration at the motel and a license tag.

[108]A. I didn't call her. I went to see her.

Q. You went to see her personally? What date was that?

A. That was the 13th, the day after discovery of the fetus.

* * * * * * *

[119] INVESTIGATOR JAMES L. WARNER, was called as a witness by and on behalf of the Defendant, having been first duly sworn by the Clerk of the Court, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. HINES:

Q. Detective, would you give your name and your occupation.

A. James L. Warner, investigator, City of Falls Church Police.

* * * * * * *

[122]Q. Was it ascertained whether or not Dr. Simopoulos' office was licensed as a hospital?

A. Yes.

Q. Okay. Now, did Patty McDonald indicate to you or had she -- were you aware that she had indicated to Detective Dooley that whatever procedure had been performed had been performed in his office?

A. Yes.

Q. So, you knew at that time it hadn't been performed in a hospital?

[123]A. That it hadn't you say?

Q. Yes.

A. Yes.

Q. Okay. So, your call to the Department of Licenses was merely a follow-up with respect to that information?

A. Yes.

Q. Okay. Would it be fair to say that on the 23rd or about the 23rd of November you were in possession of sufficient facts to charge a crime?

A. Possibly.

Q. All right. And yet you didn't arrest Dr. Simopoulos at that time?

A. Not at that time.

Q. Okay. You didn't arrest him until six days later.

A. That's correct.

Q. And six days later was the first time that he was advised of his rights?

A. As far as I know.

Q. Were you the person to advise him of his rights?

A. Yes.

* * * * * * *

[129]Q. Now, when you went to Dr. Simopoulos' office on the 29th, who did you go with?

A. It was myself, Investigator Dooley, two uniformed officers who remained outside the establishment, and Lieutenant Greg King.

Q. When you entered the office, were

there patients of Dr. Simopoulos present?

A. In the waiting room. I did not see any in the examining rooms. I didn't go back to the examining rooms.

Q. How was Dr. Simopoulos identified to you?

A. I approached the receptionist and asked to see Dr. Simopoulos. She said that he was with a patient and she would advise him to come out as soon as he could. When he came outside, I identified myself and then asked him if he was Dr. Simopoulos to which he stated yes.

Q. Okay. What did you do at that time?

A. I then advised him that I had a search warrant for the premises.

* * * * * * *

[130]Q. Was Dr. Simopoulos placed under arrest at that time?

A. Yes.

Q. Okay. Was he removed from his business before the actual search was executed?

A. It was all, you know, the search warrant was executed on him or on the premises and he was arrested about basically the same time.

Q. Okay. He was arrested prior to the actual production of the office records relating to Patty McDonald, though, was he not?

A. He had left the office before we obtained those, yes.

Q. Okay. And then he was removed to the Falls Church Police Department

where he was advised of his rights, was he not?

A. Yes. Right.

Q. He did not give a statement at that time, did he?

A. As a matter of fact, Dr. Simopoulos had been [131] released on his personal recognizance when I came back to the station. He asked us if he could discuss the matter with us. He was advised of his rights then. He signed a waiver form and then just asked us a few questions in regards to the matter.

Q. Okay. He asked you about the statute he was being charged under, did he not?

A. Yes.

Q. And he showed some knowledge about the parental consent statute.

A. That's correct.

Q. At that time he did not give any indication that he had performed any kind of abortion or any other procedure, did he?

A. Yes.

Q. He did?

A. Yes.

Q. He gave you further incriminating statements at that time?

A. He just said he was the doctor who performed the saline injection on Patty McDonald.

* * * * * * *

[136] DR. CHRIS SIMOPOULOS,
was called as a witness by and in his own behalf, having been first duly sworn by the Clerk of the Court, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. HINES:

Q. Dr. Simopoulos, would you give your name and your occupation for the record.

A. I am Chris Simopoulos. I am a certified obstetrician and gynecologist.

Q. Practicing in Falls Church?

A. In Northern Virginia.

Q. All right. Doctor, directing your attention back to November of 1979, did there come a time when you discovered that there had been a phone call to your office from the medical examiner's office?

A. Yes, sir.

Q. Okay. And have you had phone calls from the medical examiner's office before?

[137]A. Yes, sir.

Q. Okay. Previous to that?

A. Correct.

Q. All right. And normally what is the nature of those calls?

A. Inquiring about medical matters and answering any question they may have regarding patients and so forth and so on.

Q. Are you cooperative with the medical examiner?

A. Yes.

* * * * * * * *

[138]Q. Okay. Did you have any knowledge that the person that you were calling back was a police detective?

A. No, sir.

Q. Okay. Now, when you called to the medical examiner's office, do you know

who answered the phone?

A. Oh, the secretary answered the phone. I was surprised that it was the medical examiner's office.

Q. Okay. And did you ask for Mr. Dooley?

A. I said, is Mr. Dooley there, and just a moment please, the answering party told me. So then when I got him to the phone --

Q. So, did the person take the phone eventually? Did a person take the phone and identify himself in any capacity?

A. I believe he said it was Mr. Dooley.

Q. Okay. Did he ever identify himself as Detective Dooley to you?

A. I don't recall that.

Q. Okay. Now, do you recall what you said to him or what he said to you at the time he came to the [139] phone, whoever?

A. Yes, I do.

Q. What was the nature of that?

A. He asked me if I had prescribed Percodan for a patient named McDonald.

Q. Okay. Now, prior to asking you that question, do you recall him in any fashion identifying himself to you as a police officer or a detective?

A. No, I don't recall. I don't recall.

Q. Okay. Prior to his asking you that question, did he in any fashion give you any -- did he make any other statements to you with respect to your rights?

A. No, he didn't.

Q. Prior to asking you that question, did he indicate to you that you might be under arrest or you might be the subject of an investigation?

A. No, sir.

Q. Okay. Did he tell you that he had been involved in investigating the death of a fetus, of an immature fetus?

A. No, sir.

Q. Okay. And you responded to that question because you thought you were talking to somebody from the [140] medical examiner's office; is that true?

A. (Nodding head.)

* * * * * * *

A. Well, he asked me what was the prescription. I said it was -- I gave her a prescription for eight tablets of Perco-

dan. He kept asking why and what was the problem, and I said, well, I gave it to her because of abdominal and pelvic pains.

He said, is she a patient of yours. I said, yes, she is. One question lead to another and he said, what did you do for her. I admitted that I had injected salt at my Falls Church clinic.

Q. All right. Now, Dr. Simopoulos, if the person on the other end of the line had identified themselves as a police officer or as a detective and if they had told you that they had been involved in an [141] investigation and been to a motel room and found a fetus and suspected foul play, would you have responded in the manner that you did?

A. No, sir.

Q. Why not?

A. If I felt that I was the subject of criminal investigation, I would have consulted a lawyer to get his advice in this matter first.

* * * * * * *

[145] I asked him. They took me into their little investigation room and then they advised me of my rights. I said, what are the charges. He said, well, you did an illegal abortion and did so without parental consent. I said, parental consent? Yes, he said. I said, I never heard of it, and that was essentially the extent of our conversation.

Then I said I wanted to contact my lawyer and so forth and so on, which I had not been able to do, by the way.

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[159] DR. SAMUEL M. BELINSKY

* * * * * * *

DIRECT EXAMINATION

BY MR. LUCAS:

Q. Will you state your full name for the record please, sir.

A. Samuel M. Belinsky.

Q. Are you a licensed physician in the Commonwealth of Virginia?

A. Yes, I am.

Q. For how long have you been so licensed?

A. I have been in practice since 1963.

Q. And what is your area of specialization, Doctor?

A. Obstetrics and gynecology and fertility.

Q. Are you board certified by any specialty [160] boards?

A. Certified by the American Board of Obstetrics and Gynecology.

Q. Are you a member of any medical or OB/BYN organizations?

A. Yes, I am.

Q. Could you tell us which organizations they are.

A. Member of the Fairfax County Medical Society, Virginia Medical Society, Southern Medical Society, Southern Gynecological and Obstetrical Society and Washington GYN Society, to name a few.

Q. Have you held or do you now hold any teaching positions with any universities and, if so, will you describe those?

A. In our capacity of practicing in Fairfax Hospital, we have a teaching posi-

tion with George Washington University to help in teaching students and residents.

Q. And which hospitals do you practice at generally?

A. Fairfax Hospital.

Q. Is that the primary hospital or the sole [161] hospital you now practice in?

A. Sole hospital.

Q. Do your patients come from all over Northern Virginia?

A. Yes.

Q. Now, going back to 1973 after the January 22nd decision of the U.S. Supreme Court, did your practice then include any saline abortion procedures?

A. Yes, it did.

Q. And do you define saline abortion to be the injection only or to include the

expulsion of the fetus?

A. By definition the saline injection is the injection of twenty percent hypertonic saline into the uterine cavity or amniotic sac in an effort to induce an abortion.

* * * * * * *

[162]Q. I think the question was whether under the medical definition of abortion you have to have expulsion of the fetus. Do you or do you not?

A. Definition of abortion means the expulsion of the products of conception prior to the period of viability, so I would have to answer that the abortion would occur when the products are expelled.

Q. Have you had any experience with

saline abortion on an outpatient basis prior to the passage of this 1975 law that we're concerned with here?

A. Yes, I have.

Q. And could you describe to the Court the extent of that experience and where the injections were done, where the abortions were done.

A. When we first started doing it in Fairfax Hospital, the injections were done in the hospital [163] initially in an examining room. Then because of some changes in policy, they were done in the operating room suite. After the saline was injected, vital signs were monitored and the patients were observed for a short period of time, usually about a half hour.

The patients were sent home with instructions. Now, initially many of

these patients aborted at home, on the way to the emergency room or to the office, depending on the time of the day or prior to the time they got to the hospital. These patients had analgesics which are pain medications and medications to take to contract the uterus after the fetus was expelled so that the afterbirth would be delivered completely.

* * * * * * *

[164] A. From January, '78 until the present, we have done ninety-three.

Q. And where have those patients been injected?

A. They have been injected at Fairfax Hospital and the same policy has been followed, although I would have to say the majority of these have aborted in the hospital because we now have an adequate

facility to handle the patients in the hospital.

Q. Have a significant minority of them aborted elsewhere?

A. A minority have aborted either at home or on the way to the hospital.

Q. Do you consider -- Have you had an opportunity to see Dr. Simopoulos' facility?

A. Yes, I did.

Q. Do you consider that facility a suitable and safe facility for the instillation of saline solution?

[165] A. Yes, I do.

Q. Is it better equipped than the treatment room at Fairfax Hospital?

A. Yes, it is.

Q. Do you know of any hospital

between here and Richmond that permits second trimester abortion other than Fairfax?

A. I do not know of any hospitals.

* * * * * * *

Q. Let me show you what I have marked as Defendant's Exhibit 7 and ask you if that is an accurate copy of the Fairfax Hospital Policy on Abortions.

A. In view of the fact that it is labeled the Fairfax Hospital Policy on Abortions, I would have to say that it is.

Q. And does that policy require consent of the parents of the minor in the second trimester?

A. Yes, it does.

[166] Q. Do you know of any hospital in Northern Virginia where a minor can obtain

a second trimester abortion without parental consent?

A. No, I do not.

Q. Do you consider the outpatient injection of saline solution a reasonably safe medical procedure?

A. Yes, I do. When the saline amniocentesis is done in skilled and experienced hands, it is a safe procedure.

Q. Is the complication rate when the instillation is done outside of a hospital in your experience, is the complication rate outside the hospital as good as that within the hospital?

Could you compare the two?

A. I would have to say that the complication rates are probably the same. It has been shown that if the abortions are allowed to -- the completion of the abor-

tions are allowed to occur outside of a hospital setting, that there is a lot less interference by, quote, experienced personnel, unquote. These abortions will be more often complete than if they were conducted in a hospital setting.

Q. Are there any other advantages that you are [167] aware of to the outpatient procedure with second trimester saline abortion?

A. Yes, there are several advantages. First of all, the time interval after the saline is injected into the uterine cavity, there is a time interval of some eighteen to seventy-two hours prior to the initiation of the abortive process. Other things that are involved in that, the patient is not exposed to

verbal and/or nonverbal condemnation by people on the hospital unit.

Hospitals are crowded. In this day and age, admitting a patient to the hospital for observation for one to three days may deny a patient a bed who has a more urgent illness and may need that hospital bed. In this day and age of cost containment for hospital care, admitting a patient to the hospital will often increase her health care dollars anywheres from three to six hundred dollars per individual.

Having to do this procedure in that type of a setting also is restrictive as far as -- or can be restrictive as far as the patient is concerned. It may also be a breach of a minor's confi-

dentiality. Other things to take into consideration, if you force a patient to have it done in this kind of a setting, she may [168] willingly or unwillingly do something that may damage her health.

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[170] CROSS-EXAMINATION

* * * * * * *

[172] Q. I understand you to testify a shortage of beds at Fairfax Hospital, Doctor.

A. Okay. That's all I testified to.

* * * * * * *

Q. My question is, Doctor: Are you familiar with what goes on in these other hospitals?

[173] A. No, I am not.

Q. And how about Alexandria Hospital?

A. I am not a member of that hospital.

Q. You don't know what their bed situation is over there?

A. No, I do not.

Q. How about Arlington Hospital?

A. I don't have privileges there.

Q. Now, Doctor, I think you testified that between '73 and '75 you were doing salines in Fairfax Hospital and you were having the woman actually deliver the child right there in Fairfax Hospital.

A. No, I don't think I said that.

Q. What did you say?

A. I think I said that they were sent home and a good number of these aborted at home, on the way to the office,

on the way to the hospital or prior to the time they reached the hospital.

Q. But they went home under instructions to come back when it was time to abort?

A. No. They went home with instructions to call us first and then we would see them at the appropriate spot.

[174] Q. And did you testify that a majority delivered the baby in the hospital?

A. During that time interval, a majority delivered either at home, on the way to our office or to the hospital or prior to getting to the hospital.

Q. And since 1975, what does the majority do?

A. The majority are now delivered in

the hospital because we have a better unit set up to handle this policy and procedure.

Q. Now, Doctor, you don't know whether or not any of these other Northern Virginia hospitals are doing second trimester abortion?

A. To my knowledge they are not.

Q. You don't think Doctors in Arlington is doing second --

A. Nope.

Q. They aren't or you don't know?

A. They are not.

Q. As far as you are concerned they are not?

A. (Nodding head.)

Q. How about Alexandria Hospital?

A. I am not aware. I don't think they are.

Q. Do you know or are you just guessing?

[175] A. I don't know what their hospital policy is.

Q. Now, one of the dangers of the second trimester saline is the bleeding danger at the time of delivery; isn't that true?

A. Let's see. I have been doing these now some sixteen, seventeen years and I think we probably had to transfuse probably two patients during this time.

Q. Were you doing abortions back at the time they were illegal?

A. No.

Q. You have been doing saline sixteen, seventeen years?

A. Yes, sir.

Q. In this state?

A. Yes, sir.

Q. Doctor, are you familiar with the literature about the bleeding problem with saline in the second trimester?

A. I can only tell you what my experience is and the experience --

Q. I am asking you whether you are familiar with the literature, Doctor.

A. I don't think the literature dictates on what [176] I should do when I have different --

Q. I am asking you whether you are familiar with the literature, Doctor.

A. Yes, I am familiar with it.

Q. And isn't it a fact that that literature does indicate that the bleeding

problem at the time of delivery is a serious problem in second trimester salines?

A. It only occurs in one percent of the patients.

Q. When it does occur in that one percent of the patients, it is a very serious problem, is it not?

A. No, it is not.

Q. Doctor, are you familiar with the fact that there are a number of reported cases where the saline gets into the bloodstream and causes massive bleeding in the uterus?

A. Yes, I have heard of that.

Q. And are you aware of any way you could solve that problem in someone's home?

A. The only thing I can tell you is

that this has not happened in our practice.

Q. But the reports are of massive quick bleeding that unless immediate transfusion is done the patient does die.

[177] A. I don't think it is quite that catastrophic, you are building it up.

Q. Doesn't the literature report it as being that way?

A. Well, I think you have to read between the lines of the literature.

Q. I am not asking you about reading between the lines.

Doesn't the literature report it that way?

A. No, it does not.

Q. Do you know -- The figure you are giving that this happens in one percent of the cases, do you know that that is true?

A. I think Dr. Schulman reported one to two percent of patients needing to have transfusions.

Q. So, you are relying on what Dr. Schulman said?

A. And I am relying on my own experience, too.

Q. How many patients have you had where a woman actually has had bleeding in the second trimester at the time of delivery?

A. We probably had one in the last two years.

Q. And how many cases have you personally handled in the last two years?

[178] A. I think I quoted ninety-three.

Q. Ninety-three in two years?

A. Uh-huh.

Q. And where did the bleeding occur in that woman's case, home or hospital?

A. In the hospital.

Q. Doctor, I take it you disagree with Dr. Schulman then that it is important in those cases to have blood transfusion equipment available.

A. Our patient did not need a blood transfusion.

Q. So, you don't think it is important to have that available?

A. I didn't say that.

Q. Well, do you think it is important to have it available, Doctor?

A. I think this is a medical question that has to be determined at that particular time with that particular patient.

Q. Well, if you have got a case of a patient who is having massive bleeding at the time of delivery, do you think you can get by without blood transfusion equipment?

A. You can get by without blood transfusion [179] equipment until you get her to a facility where she can be handled.

Q. Now, suppose she is at home by herself?

A. When our patients are given their instructions, they are not to stay home by themselves. They always have to have somebody with them.

Q. Well, suppose a patient were not instructed that she ought to have somebody with her?

A. I can't answer that.

Q. Well, do you think it is safe for that person by themselves to be sitting at home if there is a possibility of massive bleeding?

A. This is a hypothetical case.

Q. That's right, Doctor.

A. And I am not going to answer it.

Q. You don't know or you don't want to answer it?

A. This doesn't happen in our patients.

* * * * * * *

[180] Q. Doctor, is there any reason to inject saline into the amniotic sac other than to produce an abortion?

A. I think it is accepted that the injection does usually institute an abor-

tion. The only thing is there is a certain amount that has to be injected in order to initiate the procedure.

Q. But is there any other medical illness or any other medical procedure whereby you would be doing the same thing other than to make sure you kill that unborn child?

* * * * * * *

[181] Q. Is there any other medical reason to do that other than to produce the death of that fetus?

A. The procedure is done to initiate an abortion.

Q. Right. I mean, there is nothing -- you wouldn't be treating her for anything other than to get rid of that fetus.

A. I think I stated what the pro-

cedure is done for.

Q. Yeah. And all I am trying to find out is: Is there any other reason you would give someone a saline solution injected into the uterus?

A. No.

Q. Now, you testified that your procedure in Fairfax Hospital is to inject the saline and then monitor the signs for a period of time.

A. (Nodding head.)

Q. What period of time do you do that?

A. Twenty minutes to a half an hour.

Q. What is the reason for that, Doctor?

A. Just so that we will know that the patient's [182] pulse and blood

pressure and everything is normal.

Q. And if it stays normal for twenty minutes, then everything is fine?

A. They are sent home.

Q. Okay. And then they are instructed by your group that they are to call you when they commence delivery?

A. They are to call us when they start having regular contractions or if the membranes rupture or if they have any bleeding that is heavier than menstrual period.

Q. They are instructed to call you at that time?

A. (Nodding head.)

Q. And if the bleeding begins and they call you, what happens?

A. I can't recall the last time that

we had a patient that called stating that she had the onset of bleeding.

Q. How many of these ninety-three cases were yours?

A. Oh, I'd have to say that at least half.

Q. So, you are talking about forty-five cases over the last two years?

[183] A. (Nodding head.)

Q. Some other doctor does the others or a group of doctors do the others?

A. We are all involved with their care.

Q. Okay. When in your experience with these do you tell the patient to come to the hospital?

A. When their contractions have established a good pattern and they are be-

tween five and ten minutes apart.

Q. Okay. So under your rule and your setup, they are instructed to come into the hospital for the actual delivery?

A. This has been our policy since we had a better unit established at Fairfax Hospital and more understanding nurses to handle the situation.

Q. But in any event, they are instructed to come to the hospital for the actual delivery?

A. Uh-huh.

Q. And is there a reason for that?

A. This usually saves us some time in running them through the emergency room or to the office or wherever we would be checking these patients.

Q. Isn't it a fact that you want to do that [184] because it is safer in the hospital?

A. I don't think I said it was safer in the hospital.

Q. I am asking you that, Doctor. Isn't that a fact? Isn't it safer there than to have some woman delivering the child in her home?

A. In the patients that we have had that have delivered before they got to the hospital or in the emergency room or before they got to the floor, there were no complications.

Q. I didn't ask you that, Doctor, whether there were any complications. I am asking you: Isn't it safer to have this done in the hospital than to have the woman deliver that child in her home?

A. It is safe in both places.

Q. My question: Is it safer in the hospital?

A. It is safe in both places.

Q. Do you understand my question?

A. Uh-huh.

Q. Is it safer at home or is it safer in the hospital?

A. Safer at home.

Q. It is safer at home?

[185] A. Yes, sir.

Q. Well, then why do you bother to even have them come in to the hospital at all?

A. Just ease of handling these patients when there's four of us to work together.

Q. So far as you are concerned, they

could all deliver at home and it wouldn't make any difference?

A. Under our directions this could happen.

Q. But under your directions, you tell them to come into the hospital.

A. This is only because I have three partners.

Q. Well, I take it your partners take a contrary view from you?

A. No, it just makes it ease of handling and that is all.

Q. What, would you expect you would be going out to the home at time of delivery?

A. No. These patients, we usually meet them in the hospital or in the emergency room. This is the way we used to do it prior to 1975.

Q. And what do you do now?

A. We admit them to the hospital.

Q. And that's where they deliver if at all [186] possible?

A. If at all possible.

Q. Now, Doctor, you don't know personally whether other hospitals allow juveniles to be aborted.

A. Being on the staff at Fairfax Hospital, I am not aware of other hospitals or their policies.

Q. So far as you are concerned, other hospitals could do it and there is no way you'd know about it.

A. I think I answered that to the extent that I think that Fairfax Hospital is the only one between here and Richmond that allows it to be done.

Q. That allows what to be done?

A. Saline amniocentesis and abortion.

Q. I thought you just finished saying you don't know what they are doing at Alexandria and Arlington.

A. But to my knowledge. I don't have facts.

Q. So, you don't know?

A. Pretty good idea, though.

Q. But you don't know.

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[187] REDIRECT EXAMINATION

BY MR. LUCAS:

Q. Dr. Belinsky, did you have an opportunity to look at Dr. Simopoulos' follow-up instructions? Let me show you what's marked as Defendant's Exhibit 3.

A. Okay.

Q. Do you consider those to be reasonable follow-up instructions?

A. I think that they are quite adequate and cover all the potential situations that may occur after a saline abortion.

Q. Do they cover the problem of bleeding that Mr. Horan asked you about on cross-examination?

A. Down here in answer number 6 it says: Call if you are having bleeding that is heavy, that is like a heavy menstrual flow. It's covered.

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[191] DR. EMILY MOORE

* * * * * * *

DIRECT EXAMINATION

BY MR. LUCAS:

Q. Would you state your name for the record please, Dr. Moore.

A. Emily Moore.

Q. And could you give us your educational [192] background in the field of sociology and anthropology, please.

A. I have an undergraduate degree from Cornell in anthropology. I have a master's degree in sociology from Hunter City College, University of New York. I have a master's degree in public health from Columbia University. I have a master's of philosophy and socio-medical science from Columbia University. I have a Ph.D. in socio-medical science from Columbia University.

Q. Could you describe for us what your experience in general has been in the family planning field since you completed your Ph.D. at Columbia.

A. I worked for four years in the

demographic division of a population council as a sociologist demographer primarily concerned with administering grants having to do with research on abortion and initiating a compilation of various kinds of data and information about abortion from around the world.

That resulted in a book that then was published when I moved from the population council to Columbia University's International Institute for the Study of Human Reproduction. I have written a number of articles and given any number of academic papers on the [193] subject of abortions and women's roles in fertility. Those are my two major publication areas.

I then worked as the organizer and executive director of the Nassau

County Coalition for Family Planning on Moorelland, and then I was the executive director of Planned Parenthood of Metropolitan Washington for two years. I then worked as a consultant with HEW as the person drawing up the plans for family planning evaluation for federally funded family planning services in the United States.

Just now I am completing the United States country paper on women's health for the United Nations meetings in Copenhagen this summer.

Q. Do you currently reside in the greater Washington area?

A. Yes, I do. I live in Silver Spring.

Q. For how long were you the di-

rector of Planned Parenthood of Metropolitan Washington?

A. About two and a half years.

Q. Is Planned Parenthood involved in ascertaining the availability of family planning services in the greater area, including abortion?

A. Yes.

[194] Q. Have you recently conducted a study at the request of a member of my staff on the availability of abortion services in Northern Virginia?

A. Yes, I have.

Q. Could you tell us for a start about how many hospitals there are and the counties that you surveyed?

A. Well, I was asked to look at this immediate vicinity and there were -- I looked at the American Hospital Associa-

tion's guide to hospitals and I am not sure I will catch them all from memory, but there were a total of -- it was either sixteen or seventeen hospitals.

There were no hospitals in Stafford County. I included Prince William, Arlington, Falls Church, Alexandria, Fauquier. I think that's it.

Q. Did you include the Cities of Falls Church and Arlington?

A. And Alexandria, yes.

Q. And Alexandria City, also?

A. I did.

Q. Did you use methodology that is part of your training for ascertaining what the abortion policies were?

A. Yes.

[195] Q. Did you try to find out whether or not parental consent was required?

A. Yes, I did.

Q. And did you also in your investigation attempt to see if any facilities permitted first trimester abortion but did not permit second trimester abortion?

A. Yes, I did.

Q. Confining your conclusions in your research to second trimester abortions, did you find any hospitals that permitted second trimester abortion without parental consent in the Northern Virginia area?

MR. HORAN: Your Honor, I object to that.

THE WITNESS: No, I wasn't able --

* * * * * * *

[198] THE COURT: Objection sustained.

MR. LUCAS: Your Honor, may we make an offer of proof because I think the witness' testimony is extremely important to offer the testimony subject to the objec-

tion and to have it in the record for purposes of appellate review then.

THE COURT: Go ahead and do that.

BY MR. LUCAS:

Q. Could you tell us what you found on the basis [199] as you recall it as to each different hospital's policies concerning second trimester abortion for minors in the areas of Northern Virginia that you surveyed, starting more or less with a conclusion or summary of your findings and then more detailed findings.

A. Well, the bottom line is that I found no hospital in the Northern Virginia area in the jurisdictions named before in which a minor could obtain a second trimester abortion without parental consent. In several instances the person I contacted indicated that they believed it to be the

law of Virginia to require consent for a minor in the case of a second trimester abortion.

* * * * * * *

The hospitals will frequently refer you [200] when you are inquiring about hospital policies and they say, well, it really isn't up to us, it is up to the doctors. Some further investigations suggest that that is not entirely the case. That if you ask for a different office of the hospital, you can.

For example, at Fairfax Hospital I was finally read the policy over the telephone but it took a good deal of pressure on my part to find somebody who would do that for me. In most instances, I deliberately approached the study by asking each hospital operator or the first

person to answer the telephone, I asked them all the same questions worded identically.

Q. Would you tell us what that was.

A. Yes. It was, would you please -- I am sorry. Would you please connect me with somebody who could give me some information about abortion. It was deliberately vague, it was deliberately general, and it was asked in that way so that I would see first off whom they would connect me to.

In most instances I was connected to the emergency room. I do wish I were a graphic artist and could have produced a nice chart that would show you the way in which this line of questioning led to loops and [201] circles and deadends.

In over forty phone calls I found I was referred to physicians who did not perform abortions. I was referred to clinics that performed only first trimester abortions. I was referred in a circular route right back to the person that I had initially spoken to. It was -- One of the byproducts of the attempt to determine the hospital policies was the truly remarkable documentation of the kind of odyssey that one must go through in attempting to locate both a hospital and a physician who will practice in that hospital and perform a late abortion.

As I said, I was completely unable to locate in the course of this telephone -- rather extensive telephoning any physician in this area who would do it without parental consent.

Q. Out of the fifteen hospitals who are the number that you mentioned, how many permitted second trimester abortions at all?

A. Only two.

Q. Do you recall which ones those were?

A. Alexandria and Fairfax.

Q. Did different people at different hospitals [202] give you different information about the policy of the hospital?

A. Yes. In several cases I called back to verify, and I got quite different answers. For the uninitiated it must be difficult for someone to know when they are first told no, we don't do abortions here, that the person telling you that is talking only about the clinic.

That if they persist and ask,

well, are abortions done in your hospital by private physicians, they might get a different answer. It takes a fairly sophisticated inquirer to know the difference between the clinic and the private physician operating in the hospital.

A question phrased in terms of does your hospital do second trimester abortions brings a response that hospitals don't do abortions, doctors do. So, I was often referred to individual physicans and asked, well, pursue your line of inquiry with them and not with us.

Q. Approximately how many inquiries did you have to make to finally come up with the total information that you came up with for Northern Virginia?

[203] A. Not counting answering services and the hospital that didn't answer after

fifteen rings and then I called back the next day and many busy singals, I completed over forty phone calls.

MR. LUCAS: Your Honor, I would suggest that the testimony is at least admissible to show the difficulties and the burdens that a minor would have obtained in seeking to obtain a second trimester abortion in Northern Virginia and that is directly relevant to the constitutionality.

* * * * * * *

[226] MR. HORAN: As I understand the law, I may be mistaken on this, when you get into 18.2-72 and 18.2-73 you are into affirmative defenses. It must be affirmatively raised that he is excused from the abortion law because of one of these affirmative defenses.

MR. HINES: Your Honor, the legislature never creates affirmative defenses in terms of the statute. They require -- they develop the language that if you violate it.

THE COURT: Well, if Mr. Horan stands up and shows this man has committed an abortion, period, and rests his case, then what happens from there?

MR. HINES: I think he also has to show that if it was performed in second trimester that it was not performed in a place allowed by law and that the Defendant had the requisite general intent to violate those statutes. Not the specific intent. We are not talking about specific intent but the general intent to violate the statute.

THE COURT: If he comes in and puts on evidence that an abortion was performed, no trimester [227] anything, simply that an abortion was performed in violation of 71 and rests his case, what happens then? Am I supposed to assume that this is a doctor or am I supposed to assume that he did it in a hospital?

MR. LUCAS: Your Honor, I think there is plenty of law saying that he's got to prove that this law was not -- that this abortion was not constitutionally protected and that he intended that the abortion be something that took place outside of the hospital.

If he walked in and proved that an abortion had been done, he could put two hundred gynecologists on trial in Northern Virginia. I don't think the Supreme Court

of the United States would give him the time of day with that argument.

I think the Supreme Court of the United States would tell him that he's got to prove every element of that statute and things required to make the statute unconstitutional beyond.

MR. HORAN: I think that would be true if it were in the first trimester because of what the United States Supreme Court said. I think once you go past the first trimester, I don't think it is true any longer.

[228] MR. LUCAS: Well, that first statute that he is charged under is facially unconstitutional under the Roe v. Wade decision until it is construed to incorporate the other.

THE COURT: I think you may be right.

MR. HINES: Since they have gone so far as to define --

THE COURT: Do you intend to show that it was not in a hospital setting?

MR. HORAN: Oh, yes.

THE COURT: So then I don't think the issue will come up.

MR. LUCAS: All right.

* * * * * * *

[1]

VIRGINIA:

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

- - - - - - - - - - - - - - - -x
COMMONWEALTH OF VIRGINIA, :
:
-vs- :
:
CHRIS SIMOPOULOS, :
:
Defendant :
- - - - - - - - - - - - - - - -x

Criminal Docket No. 30906

Circuit Courtroom No. 5

Fairfax County Courthouse

Fairfax, Virginia

Tuesday, April 15, 1980

The above-entitled matter came on for motions before THE HONORABLE F. BRUCE BACH, Judge, in and for the Circuit Court of Fairfax County, Virginia, at 10:00 o'clock a.m.

* * * * * * *

[2] DOCTOR THOMAS GRESSINGER,

* * * * * * * *

DIRECT EXAMINATION

BY MR. LUCAS:

Q. Will you state your name for the record.

A. Yes. Doctor Thomas H. Gressinger.

Q. Are you a licensed Virginia physician?

A. I am.

Q. When were you first licensed in the Commonwealth?

A. In 1965, I believe.

* * * * * * *

[3] Q. Are you trained and experienced in the performance of pregnancy termination?

A. Yes, I am.

Q. Does this include saline procedures?

A. Yes, it does.

Q. Have you been involved in either the injection or the delivery of saline abortion patients in the mid-trimester in your practice?

A. Yes.

Q. Have you ever been involved in a unit in which the patients were both injected and delivered outside of a hospital?

A. No.

Q. Could you relate to us what your experience has [4] been with outpatient abortion procedures starting with 1973.

A. Since 1973, all of the saline abortions that I have performed have been done on an outpatient basis. The only inpatient abortions were done prior to that time and it generally is a move to outpatient saline as opposed to inpatient.

Q. With your experience from '73 to '79, for example, approximately how many patients have you been involved with in which you injected the saline patients for termination of pregnancy?

A. I'd say somewhere between 3 and 500.

Q. Have you ever been involved with injecting them outside of the hospital?

A. No.

Q. Was there ever a unit over -- prior to the passage of this law, was there ever a unit in which the patients were injected that you were familiar with?

A. No.

Q. Have you been involved in injecting patients at the Fairfax Hospital for saline procedures?

A. Yes. All of my cases since 1973 have been at Fairfax Hospital.

[5] Q. And of those patients, could you describe approximately the amount of saline that was injected and the procedure in which that was injected.

A. Yes. We ordinarily limit the injected amount of saline to 40 grams or 200 cc's of hypertonic saline.

This is done in a variety of different ways. It's sort of a vogue thing. You do it one way for a while and then you do it another way for a while.

But currently we have a drip technique where we drip 200 cc's of hypertonic saline into the amniotic sack after removing -- or approximately anywhere from 50 to 100 cc's of amniotic fluid.

Then we observe the patient for a period of time and then discharge her.

Q. Do you allow the patients to go home or to go somewhere else to stay until labor begins?

A. Yes. We encourage this. We don't want them hanging around.

Q. Do you consider it medically unnecessary for them to stay at the hospital?

A. I think it's medically desirable to get them away from the hospital.

Q. Do you instruct those patients to return to the [6] hospital when they are going to abort?

A. Yes, we do.

Q. By your understanding of the medical definition of abortion, does it require expulsion of the fetus or not?

A. Well, the word "abortion" is always modified by another word. This then tells you what the status of the abortion is.

If it is an inevitable abortion, that means it has not been completed yet. So, it's sort of a, you know, iffy question.

Q. In your experience, have some of your patients aborted outside of the hospital?

A. Oh, yes, yes.

Q. Have some of them simply not followed instructions to return?

A. In this group, these are not the most responsible or responsive patients that you have in your practice. So, many of them disappear. You try to find them and chase after them, but sometimes you just can't do it.

Q. Have any of them ever aborted in any unusual places in your experience?

[7] A. Oh, yes, yes; motels, parking lots; yes, wherever they just happen to be at the time.

Q. Does the actual aborting of the fetus take place rather suddenly in some

cases?

A. In some people there is almost no evidence of labor pains at all and all of a sudden they just feel a rectal pressure and expel the fetus with very little warning.

Q. Do you consider it medically safe to instill the saline solution in the patient in a clinical facility outside of the hospital?

A. Yes, I think it would be medically safe.

Q. Do you know of any hospitals other than Fairfax Hospital in Northern Virginia which permit second trimester abortions?

A. Of my own knowledge I don't. Since I only use Fairfax Hospital, I have not had cause to explore what other hospitals do.

Q. In your course of communicating with other physicians, have you ever heard of any other hospitals in Northern Virginia?

* * * * * * *

[8] Q. Is the Fairfax Hospital open every day of the week for second trimester abortions or do they limit the availability?

A. They limit the injections from Monday through Wednesday so that the procedures will be complete before the weekend so that they don't have to take on additional specialized staff over the weekend.

Q. Let me ask you if you have had an opportunity to review this article which I show you entitled Outpatient Saline Abortion by Howard Shulman and others.

(Handing item to witness.)

A. Yes, I have reviewed this.

Q. Is that one of the articles on which OB/GYN's would rely as a medically accepted, accurate study of outpatient saline procedures?

A. Yes. This is acknowledged as a valid work in the field.

Q. Do you consider it an authoritative piece of work?

[9] A. Yes, I do.

Q. Does it accurately reflect your own experience with the abortion process in the midtrimester?

A. It does pretty much, except that fortunately we have fewer complications than they do which is nice, but this is almost ten years ago, so maybe we are

getting better.

MR. LUCAS: We'll mark this, I believe, as Exhibit No. 9, I believe that we are up to.

THE CLERK: Yes.

MR. LUCAS: We will mark it, Your Honor, for identification as Exhibit 9.

(The item referred to was marked as Defendant's Exhibit No. 9 for identification.)

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CROSS EXAMINATION

* * * * * * *

Q. Doctor Gressinger, as I understand, you run or are one of the prime participants in the abortion clinic on Route 236?

[10] A. Yes, sir.

Q. That's Northern Virginia --

A. Women's Medical Center.

Q. Women's Medical Center. All right.

As I understand, you have been doing that since 1973?

A. Yes, sir.

Q. And your clinic does both first trimester and second trimester?

A. No, sir.

Q. You don't do --

A. We do not do second trimester abortions.

Q. You don't do them at all? I'm not talking about in the clinic. I am talking about do you do them at all.

A. Yes. I do them in my private practice, but not at the clinic.

Q. You reserve the clinic for first trimester?

A. Yes, sir.

Q. Whenever you have a second trimester, you are aware the patient is a second trimester, then you do that at Fairfax Hospital?

A. Yes, sir.

[11] Q. Because that's what the law requires?

A. Yes, sir.

Q. In that period of time, could you estimate from '73 until now how many second trimesters you have personally been involved in?

A. The vast bulk, between 3 and 500. Prior to '73, the abortions, second trimester abortions I did were done at

George Washington University Hospital and it required two psychiatrists and a fair amount of who struck john, so probably, maybe, 40 or 50 I did do prior to '73.

Q. Now, under the Fairfax Hospital procedure, you can order an abortion and perform a second trimester abortion without the concurrence of any other physician?

A. No, no. Over 24 weeks the hospital policy is that you should have a consulting physician.

Q. That's hospital policy?

A. Yes, sir.

Q. From the 13th week to the 24th week mark, it's strictly between you and the woman as to whether you will do the second trimester abortion?

A. Yes, yes.

Q. Now, doctor, I think you indicated that the hospital wants these injections done from Monday through [12] Wednesday for reasons, I guess, of administration. They won't need more specialized staff if you do them during those days?

A. Well, the problem has been over the years that some of the nursing personnel are very negative towards the patients and it takes a particularly motivated and trained person to deal with this type of patient.

In the past, the patients, when they went into labor, were sent back to the labor and delivery room which caused terrible emotional upset to both the laboring mothers of the term babies and the saline, so a special unit was set

aside so that these patients would be treated better than they had been in the past.

Since most people work on a 40 hour week, to staff just three shifts on a 40 hour week was the reason that this was done.

Q. Does the arrangement work fairly well in Fairfax Hospital?

A. Yes, it works fairly well.

Q. You, as a medical man, are you satisfied with the setup and the facilities that are available?

A. Yes, I am.

Q. Now, doctor, in your practice, of course, you [13] are familiar with some of the complications that can ensue in the delivery aspect of the second trimester

abortion?

A. Yes.

* * * * * * *

[14] Q. It's true that the bleeding complication is a serious medical consideration in the second trimester?

A. When it occurs, it can be.

Q. And this phenomena, of course, with a 22 week fetus, you are talking about a fetus well along in the gestational process?

A. More than halfway, yes.

Q. Doctor, the bleeding phenomena, would you explain how that does occur.

A. Fortunately, that doesn't occur very much any more and one of the reasons that it doesn't occur very much any more is this business of being an outpatient.

When it used to occur, it was

when the patients were kept in the hospital and the interns and the residents and the nurses kept walking by that bed [15] and seeing nothing happen. The temptation would be to intervene, hang up the pitocin or to pull on an umbilical cord or something like this.

Most of the hemorrhages that have occurred in this occurred because of intervention and just keeping the doctors and nurses away from the patients has done more to limit this particular complication than any other single thing.

Q. Is there also a factor involved that if the saline enters the blood stream, it affects the clotting mechanism in some women?

A. Well, yeah. More than that, it

ups their circulating sodium to dangerous levels.

Q. If in fact that does occur, then that as a complication is a major medical complication, if it occurs?

A. Yes.

Q. If the woman does, at the time she begins to go into labor, if she does in fact begin to bleed, the bleeding is extremely heavy and it's a very quick evacuation of blood, is it not?

A. Well, no, because, you see, the hypernatremia happens considerably before the patient would labor and [16] any imbalance would have presented itself in another form of a complication or it would have been corrected either by the body itself or by the infusion of intravenous

fluids.

Q. Well, that's assuming that the patient is in the hospital, isn't it?

A. Well, what I am saying is wherever the patient is, you have early symptoms well before the bleeding, you know, could start and the body is such that it's able to correct this or, you know, if the patient is so sick that it has to be corrected for her, it would occur prior to the onset of any bleeding.

So, you know, if you took a patient who was hypernatremic and then cut her, yes, she would have terrible bleeding problems, but the time frame is just different.

Q. Well, if she is at home and this bleeding process starts, isn't she a major

medical risk since there are no facilities there to care for her at home?

A. If a patient were bleeding and she were hypernatremic, yes, indeed, this would occur. But the probability of it occurring at the same time is extremely remote.

[17] Q. Doesn't literature report that, though?

A. The hypernatremic people do tend to have an impairment of their clotting mechanism, yes.

Q. It's affecting the saline solution that's given them to begin with?

A. But it really doesn't occur in this particular time frame, you know. Theoretically, it is a possibility. Practically, we don't see it.

Q. You don't see it?

A. Well, it just isn't seen.

Q. The field doesn't see it?

A. I have never seen it.

Q. You haven't seen it?

A. No, or heard about it.

Q. Well, I don't follow you. It's reported in the literature as a complication with the saline solution.

A. If you take a patient who has got a high blood sodium and if you run tests on that blood, it will show a clotting deficit. So, you can say yes, this person does have a clotting deficit.

However, I have never read of or seen a circumstance where the patient is indeed bleeding at that [18] time. It's simply a lab test that says that the

potential is there, were she bleeding to be in trouble, but I have not seen a case or read of a case where indeed it actually happened.

Q. Now, of course, the injection itself is what creates the condition, isn't it?

A. Yes, sir.

Q. If it's created at all?

A. Yes, it is.

Q. We aren't talking about somebody who's got a high sodium level to begin with?

A. No.

Q. And this potentiates it?

A. But they don't start laboring at the earliest until 24 hours, and certainly by that time any high blood sodium is long past and taken care of.

Q. Well, what I am talking about is in the interim, between the time of injection and the time of bleeding, under your setup the woman is not necessarily in the hospital.

A. No, but she is also not bleeding.

Q. That's true, doctor. But in the period of time where the bleeding onset may begin, she is not in [19] the hospital.

A. That's correct.

Q. And if the bleeding does occur, it is vitally important that she be in a hospital?

A. If the bleeding should, yes.

Q. Because this form of bleeding is rapid in onset and is extensive bleeding. Isn't that true?

A. If it were to happen, but she

would be more likely to be in an automobile accident bleeding than she would from her uterus.

Q. Of course, you don't get a high sodium level from an automobile accident, do you?

A. What I am saying is if a woman were driving home from the hospital after she got injected, she has a much higher likely of having an accident than she does the bleeding from the uterus for the first 24 hours.

By the time the 24 hours is up, the high sodium in her blood is long gone.

Q. That's right. But in the meantime, before the sodium has gone through the blood system, in the meantime, the clotting mechanism is affected?

A. I think the problem here is that you are making [20] an assumption that the sodium is coming from the amniotic fluid into the maternal stream. When this happens, it's a direct intravascular injection directly from the physician at the time.

The patients who become hypernatremic don't become hypernatremic because all of a sudden the body is absorbing the sodium from the amniotic fluids because the physician inadvertently has injected right into the vascular bed.

Q. That certainly can occur in any --

A. And you know that real early. I mean real early.

Q. Well, like how early do you know?

A. Seconds to minutes.

Q. Doctor, above and beyond what you are talking about now, where the doctor physically makes a mistake in the course of the operation, isn't there also reported in the literature in many cases reports of the sodium entering the blood stream without the mistake being made by the physician?

A. Not in great quantities.

Q. But it has been reported, hasn't it?

A. Very small, very small. So much so that, you [21] know, you can do this procedure on people who have chronic renal damage. We feel secure enough that once we get in the amniotic sack, it's sequestered sufficiently from the body.

Q. When you say it's reported in the literature rarely, what are you talking

about?

A. I am talking about the intravascular injection of hypertonic saline, inadvertent.

Q. I am talking about other than that, just the invasion of the blood stream by sodium other than the intravascular injection.

A. People have run sodium levels and they have been slightly elevated, but not, you know, not dangerously at all. The patient gets thirsty. That's all.

Q. When you said that the bleeding we're talking about occurs rarely, what are you talking about when you say rarely?

I am talking now about a woman who has gotten a second trimester saline and you say rarely.

A. Hemorrhage. Hemorrhage under any circumstances is a rare complication, usually due to intervention and instrumentation by a physician.

Q. How often are you talking about; one percent of [22] the cases, two percent of the cases, ten percent of the cases?

A. It's reported somewhere around two to three percent, if you averaged out all the findings. Fortunately, ours is around one percent, usually because of a trapped afterbirth.

Q. It's accepted in the literature, then, that this is a potential complication?

A. (Nodding head.)

Q. Can we agree, doctor, that somebody with that complication should be in a

hospital?

A. Oh, well, yes, she should be attended by a physician, but whether indeed she has to be in a hospital, I'm not too sure.

Q. Well, doctor, can't we agree that if one has the onset, can we agree that this bleeding, once it occurs, is rapid and extensive?

A. It can be, but it certainly isn't always.

Q. Well, if her clotting mechanism has been affected?

A. What I am saying is that by the time she does this, her clotting mechanism is not affected because she's cleared the sodium out of her system. A young [23] healthy kid can do this in a matter of an

hour or so.

Q. Are you suggesting where the literature is saying in two to three percent of the cases, where the literature is saying this is a complication, are you saying it's not really a complication?

A. It's not because of sodium. It is a complication and the women do bleed, but not because of high blood sodium.

Q. Why do they bleed, then, doctor?

A. Because part of the afterbirth is stuck up in the uterus and part is half out and they have got a big red raw surface there bleeding.

Q. That's the complication?

A. Yes, it is.

Q. And if they are bleeding extensively, you say it doesn't make any

difference whether they are in a hospital or out?

A. It's better if they are under the care of a physician who can then get the rest of the afterbirth out. If they are in a hospital, it theoretically could be an advantage of having them there, having the equipment there, but if that equipment is present in a clinic or a doctor's office, then I don't really see [24] that it makes that much difference.

The thing is to get the stuff, afterbirth out, get it.

Q. Is a blood transfusion in order?

A. Either an expander or a transfusion. Now, even in a hospital it takes a couple of hours to get blood ready to be transfused. You have an interim thing

that you call it, you know, blood volume expander, plasma expander that you use in the interim.

Q. And that's available in a hospital?

A. That's available in a hospital and it's also available, you know, in most clinics.

Q. How about at home?

A. No, no. It's not available at home.

Q. Doctor, in all your patients, nonetheless, you instruct them to come into the hospital for the actual --

A. Yes, yes, we do.

Q. -- delivery process?

A. Yes, we do.

Q. That's because it's required by law?

A. No, no.

* * * * * * *

[25] Q. Doctor, why do you have your patients go into the hospital for the actual delivery process?

A. I think ideally it should be closely supervised and the facility is set up for close supervision. I feel it's the best facility around, so I feel it's best for my patients to be there.

* * * * * * *

[26] REDIRECT EXAMINATION

Q. Doctor Gressinger, if there is any possibility of sodium chloride being injected into the veins early in the procedure, isn't that something that a physician in a clinic can stop right away?

A. If they are using the slower drip

technique, yes. It doesn't take very long.

Q. In a clinic, can you give IV fluids to help rectify any imbalance?

A. Yes.

Q. Within the clinic?

A. Yes.

Q. The different complication possibilities that Mr. Horan was raising, are these all possibilities you have taken into account before giving your opinions on the safety of outpatient saline?

A. Oh, yes.

* * * * * * *

[27] Q. Do you recall how far back and what countries those reports and the literature might come from?

A. The earliest ones that I remember are the Swedish ones and they are, you

know, they are 1950's and '60's.

Q. Have the techniques of saline instillation improved remarkably?

A. Oh, yes. We feel they have.

Q. In recent years?

A. Yes.

* * * * * * *

[28] DIRECT EXAMINATION

* * * * * * *

[30] Q. When did you turn 18, Ms. McDonald?

A. December 21st.

Q. December 21st. So, last November you were 17. Is that correct?

A. Yes.

Q. When you first went to Doctor Simopoulos' office, how many weeks pregnant were you?

A. About 22.

Q. Were you quite certain at that time?

A. I wasn't certain.

[31] Q. It was -- just how certain were you of that?

A. It was just an estimate from the time of my last period.

Q. Had you known for the entire 22 week time, then, that you were pregnant?

A. About a month after, July.

Q. So, you had known for at least 16 weeks?

A. Yes.

Q. During that 16 week period, did you make any efforts to see a physician?

A. No.

Q. Did you do anything at all about the pregnancy during that 16 week time?

A. No.

Q. Did you discuss it with any person?

A. No. I mentioned it to my boy friend.

Q. Did you make any decisions during that 16 week time as to what you were going to do, if anything, about the pregnancy?

A. Have an abortion.

Q. So, you made up your mind 16 weeks before you went to see Doctor Simopoulos?

A. Not 16 weeks before.

[32] Q. Fourteen weeks before?

A. I don't remember.

Q. Did you discuss the matter with your parents at all before you went to

see Doctor Simopoulos?

A. No.

* * * * * * *

Q. Were you concerned about the reaction of your [33] parents?

A. Yes.

* * * * * * *

[35] Q. Did you see any other physicians before you saw Doctor Simopoulos?

A. No.

[36] Q. Why did it take you so long to go to Doctor Simopoulos?

A. Because I was trying to get some money.

Q. You indicated at the preliminary hearing that you had called around some other places about the cost of obtaining medical care.

Do you recall what other places you called?

A. No.

Q. Did you raise about all the money that you could as of the time you went to see Doctor Simopoulos?

A. Yes.

Q. Did you have any reserves at all left to cover hospital costs?

A. No.

Q. When you saw Doctor Simopoulos in the treatment room, were you given any kind of local anesthesia around the area of your navel before the injection was done?

A. I don't remember.

Q. You were not put to sleep, were you?

A. No.

Q. At the time that you were in the treatment room, did you observe Doctor Simopoulos make an injection and [37] cause certain solution to be dripped in through a tube?

A. Yes.

Q. About how many minutes did it take for that dripping to entirely take place?

A. I guess about five.

Q. Was a nurse by the name of Marcelle in the room during most of that time?

A. There was a nurse. I don't know her name.

Q. Was there also a woman who was the administrator or counselor who had dark hair? Do you recall her?

A. The receptionist?

Q. Yes.

A. She wasn't in the room, but she was there.

Q. Was she the first person who talked with you about the instructions and general information?

A. Yes.

Q. Do you recall her advising you that you could go to the hospital for the injection?

A. No.

Q. You don't recall that at all.

Do you recall your boy friend being with you when she explained the instructions to you?

A. The instructions after it was over?

[38] Q. In the beginning, first of all, when you first got there, when she first gave you instructions. Do you recall that your boy friend was with you?

A. There were no instructions in the beginning.

Q. Before you went into the original room, you don't recall any instructions?

A. No.

Q. Do you recall being given the postoperative sheet before you went into the room for the injection?

A. Afterwards I had it.

Q. You don't recall when that was given to you?

A. That was given to me after; right before I was ready to leave.

Q. Right before you were ready to

leave?

A. (Nodding head.)

* * * * * * *

Q. Do you recall after the injection Doctor [39] Simopoulos saying that he would meet you at the hospital later?

A. No.

Q. You don't recall that at all?

A. No.

Q. Did you leave the instruction sheet in the procedure room and leave without it originally and the nurse later gave it to you?

A. No.

Q. You don't recall that at all?

A. It was given to me afterwards.

Q. Did you ever put the instruction sheet down and try to leave the room

without it?

A. Right after she gave it to me, I was going to leave it there. Then she called me back.

Q. So, you do recall her having to give it back to you at least one time?

A. After it was over.

Q. Was that the nurse or the --

A. Receptionist.

Q. -- receptionist who gave it back to you.

When the receptionist gave it back to you, she went over the instructions with you again, didn't she?

[40] A. She never went over them. She just said read them.

Q. Did you tell her you had read them?

A. I hadn't a chance then.

Q. At the time she gave them back to you, where were you?

A. In the hall, right five seconds after she gave them to me the first time.

Q. You were out in the hallway getting ready to leave?

A. Uh-huh.

Q. You were with your boy friend, then, when she gave them back to you?

A. Yes.

Q. Do you recall her circling the doctor's phone number on the instruction sheet?

A. She might have.

Q. How many times do you recall the receptionist telling you to go to the hospital after pregnancy began?

A. Never. Only if it was severe.

Q. Never at all?

A. It wasn't her who told me.

Q. How many people told you to go to the hospital [41] after the injection?

A. Only one.

Q. Was that the nurse or Doctor Simopoulos?

A. It was the doctor, but only if it was severe. Otherwise, he said it was okay if I didn't go to the hospital at all.

* * * * * * *

Q. Do you deny that Doctor Simopoulos told you that he would meet you at the hospital after cramps began?

A. Yes. He never said that.

Q. Do you deny that the receptionist told you to go to the hospital after

cramping began?

A. Yes.

* * * * * * *

[42] Q. At the preliminary hearing you indicated to us you had had no medical complications after the procedure. Is that correct?

A. Yes.

Q. Is that still the case?

A. Yes.

* * * * * * *

[46] THE COURT: Do you want to argue?

MR. LUCAS: Yes, Your Honor. I think I might argue briefly on them, unless the State has any evidence.

MR. HORAN: No, Your Honor. We will submit it on the evidence.

MR. LUCAS: As the evidence stands, I

think we have conclusively shown that the first and second trimester saline abortion procedure can be very safely done outside of a hospital on any interpretation of the Statute which the Commonwealth offers.

The Commonwealth has not offered any evidence to refute any of the testimony. We have had physicians with an enormous amount of experience in this area.

I think we have shown in the Supreme Court's language that the second trimester hospitalization requirement in Virginia is simply not reasonably related to maternal health, but in fact imposes a severe burden upon physicians and patients by sharply limiting access to facilities.

We have had testimony of only one hospital in Northern Virginia that even

permits second trimester abortions, put the policy of that hospital into evidence and the hospital requires parental consent. [47] It shows conclusively a tremendous burden upon people seeking access to second trimester abortion.

We have had witness after witness testify as to the suitability of Doctor Simopoulos' facility which is certainly going further than we need to attack the Statute, and we have had witness after witness testify as to how the second trimester saline abortion procedure is done, how it does not require hospitalization at either end and how it can therefore be done safely on an outpatient basis.

Another angle to the Statute is the Statute is discriminatory. It singles out

abortion. Abortion is the only procedure in the State of Virginia that is required to be done in a hospital which places a certain burden on the Commonwealth to come forward.

Now, if we read the Danforth case carefully and if we read the Roe case carefully, we handed up the Danforth case yesterday and I have an extra copy of the slip opinion, the same one that Mr. Horan has of the Roe case. I have dog-eared the particular relevant pages.

The Court will see that in Roe v. Wade that a second trimester hospital requirement was not at issue. The Court stated general guidelines as to how to deal with [48] that issue. Later on they said that the State has to show some compelling State

State interest and to show that the Statute is narrowly drawn.

* * * * * * *

[49] The practice and the medical studies in the last few years have revealed the extent to which the hospital requirement burdens patients and burdens physicians because the hospitals don't permit abortions.

Another bad aspect about the statutory scheme here is that the Commonwealth allows a hospital to refuse to do abortions. The Commonwealth has a Statute saying a hospital can refuse any abortions, if they want to, even if you have willing physicians and nurses and facilities.

So, that Statute tied in with the parental consent requirement, tied in

with the hospitalization requirement amounts to a severe burden on physicians and patients. I think we have demonstrated here that that burden is quite unnecessary.

Prior to the time that the Statute was passed, people were very comfortable with doing saline abortions [50] on an outpatient basis here. We still have physicians telling us again and again you simply don't have control over the patient after the patient is injected.

We have heard different interpretations of the law. I am not even certain what interpretation the Commonwealth is offering, and that is another argument that we made in our motions.

The Statute, as it is written, has

that last clause, "provided such procedure is performed in a hospital." A physician looking at that, using the definition of abortion, might not think the prosecution would say that you have to do all aspects of the procedure within the hospital.

I'm not even sure from the representations of the Commonwealth at this point whether the Commonwealth thinks it's illegal to do the injection in the clinic or illegal to allow the delivery to take place other than a hospital or whether that depends on the follow-up instructions that are given and what if the patient doesn't follow the follow-up instructions or even worse if the patient denies that follow-up instructions were given.

* * * * * * *

[51] The Indictment itself, as we have discussed earlier, has real problems in the way it is written. [52] The Indictment seems to charge only under the first Statute, but under 18.2--71, yet it uses terminology out of the second Statute. The Indictment fails to negate the exception in 18.2--74.1 about the possibilities of the procedure being needed in order to save the patient's life and the interpretation of saving the patient's life, if that includes her health or not.

We haven't gotten into that with this witness, but the Statute itself doesn't negate that.

If the Court looks at another case that we have copies of, U.S. v. Vuitch, it's in 402 U.S., decided by the Supreme

Court in 1971 or 1972. I forget which.

That case discusses the need for the Commonwealth to have in its Indictment and in its proof beyond a reasonable doubt all of the elements of the crime.

The Commonwealth cannot take this first Statute, which standing by itself is patently unconstitutional under Roe v. Wade, they can't take the first Statute and charge every physician with doing an abortion in the Commonwealth and then expect the physician to come forward and prove exceptions out of it.

Under the requirement of presumption of [53] innocence and proof beyond a reasonable doubt, under the due process clause of the Fourteenth Amendment, the Commonwealth has got to allege all the

elements and negate all the exceptions, unless it's something of a different story like an alibi.

* * * * * * *

[69] THE COURT: Mr. Lucas, I appreciate your argument. I am going to deny your motion.

I am certainly not going to go further than the Supreme Court, that I believe the Supreme Court has gone at this point.

There is in this community the availability of Fairfax Hospital which certainly does these second trimester abortions. Their facilities are available to the Defendant in this case.

Furthermore, from the evidence I have heard, I frankly believe that the regulations that the Virginia Legislature has

imposed on second trimester abortions are reasonably related to maternal health and are not unconstitutional in any way.

So, I will deny your motion.

* * * * * * *

Defendant's Exhibit 3
and
Commonwealth's Exhibit 6

POST-INJECTION INFORMATION

THINGS TO KNOW:

You have had a surgical procedure. There is a wide range of normal reactions to the saline injection.

1. Contractions (cramps)
   You may experience crapms (sic) during the procedure. The cramps are a sign of the uterus contracting. This early cramping is in reaction to the medication being injected and does not necessarily mean that the fetus will be expelled early. Early cramping often fades. Cramping begins about an average of 12-24 hours after the injection. You will have a pseudo-labor.

2. Backache or tenderness at the bottom of the abdomen.

3. Amniotic fluid (bag of waters)
   The bag of waters may break, e.g., amniotic fluid may be expelled the first night or anytime the next day. The fluid may be clear or blood-tinged - these are normal reactions. Breaking the bag of waters may or may not be accompanied by contractions

(cramping).

4. Other signs and symptoms may include nausea, thirst, diziness (sic), bleeding (or bloody show).

WHAT TO DO:

1. Activity when you return home: Light activity is allowed. Do not confine yourself to bed waiting for the first signs of labor. Keep yourself occupied with reading, very light housework - cooking, knitting, watching TV, etc.

2. You may eat light meals and drink fluids (but no alcoholic beverages).

3. Do not engage in any sexual activity, no tub baths, or isert (sic) anything into the vagina during this period.

4. Report to the hospital when you begin having contractions that are 10 minutes apart and lasting 30 seconds or more. Do not eat or drink anything after you begin having contractions.

5. Come to the hospital when your bag of waters breaks, regradless (sic) of whether you have contractions or not.

6. Call if you are having bleeding that is heavy (e.g., like your menstrual flow).

7. Call if nothing happens 48 hours after the procedure was performed, (salt injection).

Chris Simopoulos, M.D., FACCG
Telephone: (703) 491-3366
(703) 550-9387

Defendant's Exhibit 7

THE FAIRFAX HOSPITAL

POLICY

ABORTIONS

Effective February 1, 1977 and pursuant to the laws of the Commonwealth of Virginia (Section 18.2-71 through 18.2-76.2), the policy of The Fairfax Hospital for the termination of a human pregnancy by performing an abortion or causing a miscarriage shall be as follows:

1. The procedure must be performed by a physician who is licensed by the Virginia State Board of Medicine to practice medicine and surgery.

2. DURING THE FIRST AND SECOND TRIMESTERS OF PREGNANCY a physician may terminate or attempt to terminate a human pregnancy or assist in the termination of a human pregnancy by performing an abortion or causing a miscarriage, provided a proper consent is obtained.

3. SUBSEQUENT TO THE SECOND TRIMESTER, a physician may terminate or attempt to terminate a human pregnancy or assist in the termination

of a human pregnancy by performing an abortion or causing a miscarriage, provided the following conditions are met:

a) The physician and two consulting physicians certify and so enter in the Hospital record of the woman that, in their medical opinion, based upon their best clinical judgment, the continuation of the pregnancy is likely to result in the death of the woman or substantially and irremediably impair the mental or physical health of the woman.

b) Measures for life support for the product of such abortion or miscarriage must be available and utilized if there is any clearly visible evidence of viability.

c) If, in the opinion of the physician so performing the abortion or causing the miscarriage, it is necessary to terminate a human pregnancy or assist in the termination of a human pregnancy by performing an abortion or causing a miscarriage on any

woman in order to save her life, then the conditions specified in (a) and (b) above shall not be applicable.

4. Before performing any abortion, miscarriage, or otherwise terminating a pregnancy, the physician shall obtain the written consent of the woman if legally competent to give such consent. If the woman has been adjudicated incompetent by a court, then the physician shall obtain the written consent of the guardian or committee appointed by the court. If the woman is a minor (under 18 years of age), AND IN THE FIRST TRIMESTER OF PREGNANCY, a physician shall prepare and have the woman sign an informed consent which explains in layman's language the nature of the procedure, the risks incident thereto, and the effect thereof; the physician shall also furnish a written statement that in his opinion the minor is of sufficient maturity to understand the matters explained in the informed consent and to give her effective consent to the procedure. IN THE CASE OF THE MINOR PATIENT, SUBSEQUENT TO THE FIRST TRIMESTER OF PREGNANCY, THE INFORMED CONSENT OF THE PARENT AND/OR GUARDIAN MUST BE OBTAINED.

a) Form ADM99-R-12-76, attached, is provided for use by the attending physician in securing the consent of the patient to perform an abortion. Form ADM99-R-12-76, properly executed, shall be in the patient's chart prior to termination of a human pregnancy by performing an abortion or causing a miscarriage.

b) For those abortions performed after the second trimester, Form ADM118-75, properly executed, shall be in the patient's chart prior to the termination of a human pregnancy by performing an abortion or causing a miscarriage.

5. Any employee of The Fairfax Hospital who shall state, in writing, an objection to any abortion or all abortions on personal, ethical, moral or religious grounds, shall not be required to participate in procedures which result in such abortion.

s/ S. David Youngdahl 20 December 1976,
Effective Date: 1 February 1977

[1]
VIRGINIA:

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

----------x
COMMONWEALTH OF VIRGINIA, :
-vs- :
CHRIS SIMOPOULOS, :
Defendant. :
----------x

Criminal Docket No. 30906

Circuit Courtroom No. 5
Fairfax County Courthouse
Fairfax, Virginia

Tuesday, April 15, 1980

The above-entitled matter came on for trial before THE HONORABLE F. BRUCE BACH, Judge, in and for the Circuit Court of Fairfax County, Virginia, at 11:30 o'clock a.m.)

* * * * * * *

[6] OPENING STATEMENT ON BEHALF OF THE COMMONWEALTH

MR. HORAN: The evidence we will present to you is that on November 8th, 1979, a young girl, who at that time was 17 years of age, went to the office of this Defendant, located on West Broad Street in the City of Falls Church.

* * * * * * *

[7] On Saturday morning she showed up at the clinic, slightly before noon and eventually, shortly after noon she went into the doctor's surgical room. They engated in a procedure whereby saline was injected into her abdomen, into the amniotic sack and eventually she finished that procedure, rested for a period of time and out in the outer office paid the receptionist $475 for the procedure, picked up a set of instructions, left and went to

the Howard Johnson Motel in Springfield.

She arrived at the Howard Johnson Motel on the afternoon of Saturday, November 10th. She went there with her boy friend. She remained there for the better part of the next 48 hours and sometime early in the morning of Monday, the 12th, she began to go into labor and eventually in the motel room by herself she delivered that child in the bathroom of the room she [8] had rented.

* * * * * * *

Our evidence will be the girl told essentially the same story. It will be the position of the Commonwealth that based on all the evidence that this particular offense was committed at his office on West Broad Street in Falls Church, and by

stipulation of both parties, counsel for the Defendant and myself, we will stipulate that the location at 916 West Broad Street, Falls Church, is not a hospital licensed by the State Department of Health or under the control of the State Board of Mental Health or Mental Retardation.

I would at this time, Your Honor, offer the stipulation that we have entered into.

THE COURT: I will make the stipulation a part [9] of the record in the case.

MR. HORAN: I would ask that that be Commonwealth's Exhibit No. 1 on the evidence.

(The item referred to was marked as Commonwealth's Exhibit No. 1 for identification and was received in evidence.)

* * * * * * *

MR. LUCAS: Your Honor, the Defense will reserve their opening statement to the close of the evidence presented by the Commonwealth.

I want to make sure I understand precisely how the Commonwealth is charging the offense. I understand from the opening statement that the charge is that the injection of the saline procedure at his clinical facility, under the circumstances alleged, is the offense; not the delivery in the motel.

That's not specified in the Indictment.

THE COURT: Am I supposed to respond to that?

MR. LUCAS: Perhaps you could direct the Commonwealth to more specifically state what it considers the elements of the

offense to be, then.

MR. HORAN: I'm sure Mr. Lucas can make any [10] proper argument he feels is necessary at the end of the Commonwealth's case, Your Honor.

THE COURT: They certainly wouldn't be bound by anything that he said at this point anyhow, so go ahead, Mr. Horan. Call your first witness.

* * * * * * *

DIRECT EXAMINATION

BY MR. HORAN:

Q. State your full name, please, and your occupation.

A. James R. Dooley, Junior. I am an investigator with the Fairfax County Police Department.

* * * * * * *

[11] A. I had been notified over the police radio to respond to Room A-8 at the Howard Johnson Motel in reference to a dead child that had been found in the motel room.

Q. Will you tell His Honor what you found when you arrived.

A. Upon my arrival at Room A-8 at the Howard Johnson's, I first spoke with the uniform officer on the scene who related to me essentially what she had learned upon her arrival.

I found the motel room to be a single room with a bathroom off of it. Upon entering the bathroom it was pointed out to me in the trashcan there that what appeared to be a dead child was in the trashcan in that bathroom.

* * * * * * *

[15] Q. Now, Investigator Dooley, what if anything did you do with the wastebasket that is shown in Commonwealth's Exhibit No. 2?

A. Doctor Cooper, who is the County Medical Examiner, responded to the scene and at his direction I was ordered to take the bag and its entire contents to the morgue at Fairfax Hospital so that an autopsy [16] could be performed on the fetus.

Q. Did you in fact do that?

A. Yes, sir, I did.

Q. Did that fetus stay in your possession until you got to Fairfax Hospital?

A. Yes, sir.

Q. Will you tell us where you went

upon your arrival at the hospital.

A. I went to the Medical Examiner's Office in the morgue at Fairfax Hospital.

Q. What was the purpose of going there?

A. So that an autopsy could be performed on the fetus.

Q. Did there come a time when that was done?

A. Yes, sir.

Q. When and where was that performed?

A. That was done at the morgue at Fairfax Hospital and I would estimate probably around 3 p.m.

Q. On the same day?

A. The afternoon of the 12th, correct.

Q. Who was present at the autopsy?

A. Doctor Wiecking performed the autopsy. Also present was Doctor Cooper and Doctor Beyer, Doctor Enos [17] and myself.

Q. I show you this photograph and ask can you identify it.

(Handing item to witness.)

A. That reflects the fetus and the afterbirth as it was laid out on the autopsy table in the morgue.

Q. That's the same fetus you got out of the motel that day?

A. Yes, sir.

* * * * * * *

Q. Were you also present during part of that autopsy?

[18] A. Yes, sir.

Q. Now, did there come a time when

you had a conversation on that day with the Defendant in this case?

A. On the telephone, yes, sir.

* * * * * * *

Q. Approximately what time did you talk to him?

A. Shortly after my arrival at the morgue. I would estimate probably 3:10 or 3:15 in the afternoon.

Q. What was your purpose in calling him?

A. As a result of a search that had been done in the motel room, a prescription bottle had been found in a trashcan in the motel room with the label in the bottle indicating the prescription for percodan for Patty McDonald and the doctor's name on that label was Simopoulos.

Q. I show you this prescription bottle and ask you if you can identify it.

(Handing item to witness.)

[19] A. This is the prescription bottle that was taken from the trashcan in the motel room.

MR. HINES: I don't see how we can have any objection to that.

MR. HORAN: I would offer that into evidence as Commonwealth's Exhibit No. 4.

THE COURT: I will receive this as Commonwealth's Exhibit 4, then.

(The item referred to was marked as Commonwealth's Exhibit No. 4 for identification and was received in evidence.)

BY MR. HORAN:

Q. As I understand it, based on that prescription bottle, that was the reason you were calling Doctor Simopoulos?

A. Yes, sir.

Q. Explain to the Court how that conversation took place.

A. When we found the prescription bottle, we did not know -- I did not know if the prescription was legitimate, if the medication that was in the bottle was percodan as the label read and it was investigative [20] curiosity.

With the assistance of Doctor Cooper, the County Medical Examiner, he called the People's Drug Store that had filled the prescription and from the prescription slip itself, obtained the phone number through

the pharmacist for Doctor Simopoulos.

He gave that number to me. I then called that number and asked to speak to Doctor Simopoulos and was told by either the secretary or receptionist, it was a female voice that answered the phone, that he was not there.

I explained who I was and just related that I needed to talk to Doctor Simopoulos as soon as possible and requested that he call me at the Medical Examiner's Office at Fairfax Hospital and left the number.

Approximately five minutes later I received a call from a man identifying himself on the phone to me as Doctor Simopoulos. I asked him if he had prescribed percodan for Patty McDonald.

He related to me that he had, eight or so tablets. I then asked him if Patty McDonald was a patient of his, had he recently seen her. He stated that he had. I asked what the nature of, you know, [21] her treatment or visit was and he stated that he had done an abortion.

It was at this point that he asked me what the nature of these questions was and I related to him that we had found what appeared to be a fetus in a trashcan at a motel room. We were at the Medical Examiner's Office having an autopsy performed on the fetus at that time.

He then asked me how far along the fetus was. My response to him was that I did not know as the autopsy had not been completed. That was the end of the phone call.

* * * * * * *

[22] Q. I show you that item and ask you if you can identify that.

(Handing item to witness.)

A. Yes, sir. This is another piece of paper that was found in the trashbag along with the fetus. It's entitled Post-Injection Information.

MR. HORAN: I would offer that into evidence, Your Honor, as Commonwealth's Exhibit No. 6.

THE COURT: I will receive it as No. 6.

(The item referred to was marked as Commonwealth's Exhibit No. 6 for identification and was [23] received in evidence.)

* * * * * * *

CROSS EXAMINATION

BY MR. HINES:

Q. Detective Dooley, had you had any experience investigating homicides before?

A. Approximately, I had been assigned to the homicide squad approximately six months.

Q. Had you ever investigated an abortion before?

A. No, sir.

* * * * * * *

Q. To your knowledge, were any fingerprints taken from the room ever determined to be any identity of any person who you had not known to be involved in the case?

A. An Identification officer did

respond to the scene and collected articles which were checked for [24] latent fingerprints. No comparisons were ever made.

* * * * * * *

[25] Q. Now, did you discover that there was a direction in there to Patty McDonald to go to the hospital at some point in time?

A. There was a direction on the sheet for the patient to go to the hospital. Her name was not mentioned on that sheet.

Q. Now, subsequent to your finding of that sheet, however, you did discover Patty McDonald was in fact a patient of Doctor Simopoulos that those specific [26] directions were given to?

A. Subsequent to finding that sheet,

yes, sir.

Q. Did you discuss that sheet with her?

A. Yes, sir.

Q. Did you ask her whether she had followed the directions and had gone to a hospital?

A. Yes, sir.

Q. What did she say?

A. That she had not.

Q. Did you ask her why she had not gone to a hospital?

A. Yes, sir.

Q. What was her answer to that?

A. Because she had been told by Doctor Simopoulos that she didn't have to go to a hospital.

Q. That she didn't have to go to a

hospital?

A. That's correct.

Q. When did he supposedly tell her that?

A. On the day that the saline solution was injected.

* * * * * * *

[30] A. That's correct.

Q. And as a result of your investigation, did there come a point in time when you discussed the nature of the charge with Doctor Simopoulos?

A. That would have been on the date of his arrest.

Q. That would have been on the 29th, would it not?

A. Yes, sir.

Q. Isn't it true that you told him

on the date of the 29th when you were discussing the charge with him that he was being charged with performing an abortion without parental consent?

A. No, sir. That's not correct.

Q. Did Detective Warner advise him of that in your presence?

A. I spoke with Doctor Simopoulos and had a copy of the Code Section with me, as it is written in the Virginia Code Book that I had access to.

In that Code Book, it was pointed out in one of the subsections that a second trimester abortion had to be performed in a hospital licensed by the State Department of Health or a hospital of Mental Retardation, what have you.

[31] It was also written in the Code

Section that I had that parental consent was needed, but in discussions that I had had with other people, and I indicated this to Doctor Simopoulos, I did not know if that particular section was still applicable.

He pointed out to me the fact that he knew that there was a Supreme Court ruling that that section was no longer good.

Q. So, he pointed out to you that he was aware that the parental consent was not required?

A. That's correct.

Q. Would it be a fair statement to you to say that he also indicated a complete lack of knowledge of the other Statute, however?

A. Yes, sir.

Q. The Statute he was charged under. So, he had some knowledge of the law with respect to parental consent, but he wasn't aware of the Statute he was eventually charged with?

* * * * * * *

[34] Q. Would you describe Doctor Simopoulos' office as a clean and proper looking place?

A. It appeared to be.

Q. And he kept medical records, did he not?

A. Yes, sir.

* * * * * * *

[36] Q. Were the records kept in an orderly fashion?

A. Yes, sir.

Q. Were the files kept in an orderly manner?

A. Yes, sir.

Q. Was the office clean and did it look to you like a proper medical office?

A. Yes, sir.

Q. Doctor Simopoulos did not hide any records or hide any indication that he had dealt with Patricia McDonald, did he?

A. No, sir.

Q. At no time did he ever indicate to you that he felt guilty or was hiding any indication of what had gone down, had he?

A. No, sir.

* * * * * * *

[38] DOCTOR DAVID K. WIECKING,

* * * * * * *

[39] DIRECT EXAMINATION

BY MR. HORAN:

Q. State your full name and your occupation.

A. David K. Wiecking. I am a physician and Medical Examiner for Virginia.

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[40] A. I am in charge of the Medical Examiner's System in Virginia which is the physicians who investigate violent and suspicious death cases in Virginia, and I perform postmortem examinations upon victims of such type of cases.

Q. Can you estimate how many post-mortem examinations you have done in your career?

A. Several thousand.

Q. Based on those postmortem examinations, are there occasions when you testify in Court as to your findings?

A. Yes, sir.

Q. Doctor, directing your attention to November 12th, 1979, did you have occasion to perform an autopsy at the morgue at Fairfax County Hospital?

A. Yes, sir.

Q. I show you this photograph which has been marked as Commonwealth's Exhibit No. 3 for identification and ask you is that the fetus on which you performed an autopsy.

(Handing item to witness.)

A. This is a photograph of a fetus on the morgue table, labeled NV80579 which is the case number for this case, yes, sir.

[41] Q. Tell His Honor what your physical findings were with regard to that fetus.

A. Well, the examination of the fetus revealed it to be a male fetus, a placenta and the cord are attached. The fetus was 28 centimeters in length from the top of the head to the heel and the fetus weighed 495 grams.

Other than that, it was a generally normally developed fetus for that gestation alleged.

Q. Doctor, did you examine the vital organs of that fetus?

A. Yes, sir.

Q. Based on your examination, did you form an opinion as to what the cause of death was of that fetus?

A. Well, my opinion is that it was

born dead.

Q. Were the physical findings you made consistent with the fetus that had died through an abortion process?

MR. LUCAS: Objection, Your Honor. That's a big question that calls for speculation. It doesn't lay any foundation as to what on earth he is trying to compare it with.

He can ask specifically what the cause of death was in this case, but its consistency with some other [42] things --

MR. HORAN: He is an expert witness, Your Honor. He can give an opinion.

MR. LUCAS: It's a leading question too.

THE COURT: Objection sustained as to the leading nature of the question.

* * * * * * *

Q. A fetus that size and weight, is that normally delivered at the age at which you found it?

A. Well, most pregnancies go to term at nine months, but other pregnancies terminate through abortion, spontaneous or otherwise, at times less than nine months.

Q. Do you have an opinion in this case as to what the cause of the expulsion of this fetus was?

MR. LUCAS: Objection, Your Honor. Lack of a [43] foundation as to the basis of his opinion and opinion answers cannot be given on the basis of speculation or the basis of lack of fact.

MR. HORAN: I will withdraw that

question, Your Honor.

* * * * * * *

Q. Doctor, tell the Court how one goes about determining the age of a fetus.

A. Well, the principal guidelines are the length and the weight of the fetus, and then by reference to standard obstetrical charts, you can determine the age in weeks, approximately.

Q. When you determined that age or week, approximately, are you saying that it is exactly so many weeks of gestational age or are you giving an approximation?

A. It's an approximation.

Q. Doctor, do you have an opinion based upon reasonable medical certainty as to the approximate age of this fetus?

A. Yes, sir.

Q. What is that age?

A. Five and one-half months.

MR. HORAN: I have no further questions, Your [44] Honor.

THE COURT: Cross examination.

* * * * * * *

Q. Are any of your autopsies other than this one done on fetal specimens?

A. We have a certain number of cases every year where fetuses are found discarded in public places and what not, where fetal examination is performed, yes.

Q. Is that a very small proportion of your autopsy work?

A. Yes.

Q. You also do autopsies on fetuses that are spontaneously aborted?

A. If they are discarded in a public place where they are found by a police

officer and so forth, they will be brought to us for examination.

[45] Q. You indicated on your investigation report that the manner of death was natural, did you not?

A. My report doesn't have a ruling on the manner of death. The Fairfax County Medical Examiner Report is perhaps what you are referring to.

Q. Was that part of -- were you participating in the preparation of that investigation? Were you familar with that statement that the manner of death was natural?

A. I have the original report here, yes.

Q. And you made no contradiction of that report, did you?

A. No.

Q. Is that what is normally marked when there has been a spontaneous abortion of some kind?

A. In my opinion, that would be the proper category, yes, sir.

Q. You gave immaturity as the cause of death in your report. Is that correct?

A. Yes, sir.

Q. And no question in your mind about this fetal weight being in the non-viable category, is there?

A. 495 grams is at the very bottom of any possible survivability outside the womb.

[46] Q. Isn't the usual survival weight in the neighborhood of 2500 grams, five times that?

A. The classic definition of prematurity is under 2500 grams, but the survival capacity of any fetus under 750 grams is virtually nill, even today.

Q. Have you ever had any experience with saline abortion procedures?

A. I do not perform them, no, sir.

Q. Have you ever had any experience doing autopsies on the products of saline abortion procedures?

A. Not except this one.

Q. From your investigation, you cannot say that saline was tied to the cause of death in this case, can you?

A. Except by circumstantial evidence, which there seems to be a lot.

Q. But you can't say on the basis of your investigation, you did not put that in

your report and you are relying solely on circumstantial evidence from other people. Is that correct?

A. That's correct.

Q. From your own evidence and your own examination, you did nothing to ascertain whether saline had caused [47] any death of the fetus. Is that correct?

A. From examination of the body of the fetus itself, I cannot say that saline, to the exclusion of all other instrumentalities, caused this fetus to be expelled, no, sir.

Q. Aren't there many other causes of the expulsion of a fetus?

A. You can have spontaneous abortions.

Q. Doesn't that happen in about a

third of all pregnancies?

A. I am not certain about a third, but it does happen.

Q. Isn't it a fairly high percentage, at least a fourth?

A. I don't know from personal experience what percentage of normal pregnancies abort at five and a half months. I am sure it must be in the literature somewhere.

Q. You are not familiar with any studies in the literature indicating that the spontaneous abortion rate of all pregnancies is as high as one-third or one-fourth?

A. I am not familiar with that literature, no, sir.

* * * * * * *

[49] THE COURT: I think the Virginia Code provides for it. I will receive it into evidence.

(The item referred to was marked as Commonwealth's Exhibit No. 7 [50] for identification and was received in evidence.)

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INVESTIGATOR JAMES L. WARNER, called as a witness by Counsel for the Commonwealth,

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[52] Q. In the course of that search, did there come a time when you found a spiral notebook that was set forth in the search warrant?

A. Yes, we did.

Q. Do you have that with you?

A. Yes, I do.

Q. Will you show it to me.

A. It's this notebook here. (Indicating)

MR. HINES: The objection would go to my motion to suppress, your Honor.

MR. HORAN: Your Honor please, I would offer this into evidence as Commonwealth's Exhibit No. 8, please.

THE COURT: I will receive it into evidence as Commonwealth's No. 8.

(The item referred to was marked as Commonwealth's Exhibit No. 8 for identification and was received in evidence.)

BY MR. HORAN:

Q. Rather than take the time of the

Court to read [53] it, Investigator Warner, did you find Patty McDonald's name on that sign-in sheet?

A. Yes, I did.

Q. In how many places?

A. Two times.

Q. Is that both November 8th and November 10th?

A. Correct.

Q. What else if anything did you take out of the doctor's office?

A. Also removed a file on Patty McDonald, a medical file and a card, a statement pertaining to the charges for services rendered.

Q. Is this the file that you are talking about? (Indicating)

A. Yes, sir.

Q. The red file with Patricia McDonald on top?

A. That's correct.

Q. Were all of these items in the file when you found them in the doctor's office?

A. Yes, sir.

* * * * * * *

[54] There are actually three items in the file. I would offer that into evidence as one exhibit, Commonwealth's Exhibit No. 9.

THE COURT: I will receive it, then, as Commonwealth's No. 9.

(The items referred to were marked as Commonwealth's Exhibit No. 9 for identification and were received in evidence.)

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[64] EVANGELINE KARAGEORGES,

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DIRECT EXAMINATION

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Q. State your full name, please, and your occupation.

A. Evangeline Karageorges. I am the administrative manager for Doctor Simopoulos.

Q. Were you so employed in November of 1979?

A. Yes.

[65] Q. I wonder, could you tell us what this item is and what it's used for? (Indicating)

A. It's a sign-in sheet of all the patients that come in on certain days so that I will know who is there.

Q. Can you tell from that book whether or not Patricia McDonald was there on November 8th and November 10th?

A. We usually date them. Yes, both days.

Q. Now, ma'am, could you tell me what this red folder is. (Indicating)

A. It is a patient's chart. We require the patient to fill out this information here which is her family and personal history, anything that's important.

We require that they put down the first day of their last period and this is a registration slip that gives us personal information on the patient.

Q. You are talking now about the white registration slip that is on the left-hand side of the file. Who fills out

all that information?

A. The patient, and if there is anything more we need, I question her myself.

Q. Now, on the yellow, patient's yellow folder, at [66] the top it says Gynecology, the top part is filled out also by the patient on that yellow form?

A. Uh-huh.

Q. Now, whose writing is it at the bottom of that form?

A. Doctor Simopoulos.

Q. And you are familiar with his writing?

A. Yes.

Q. How long have you worked with the doctor?

A. For almost two years, since June, '78.

Q. Ma'am, I wonder, could you tell us what that writing says in the area of Diagnosis on the bottom of that yellow form.

A. You want this here, Remarks and Laboratory. This means that it's normal and then for Diagnosis, it says pregnancy, 5 months, and then underneath, scheduled for saline injection.

Q. Scheduled for saline injection?

A. Uh-huh.

Q. And then what is it below that? What's that line having to do with treatment say?

A. This is when she came back on the 10th, the date on this. See, this remark here, (Indicating) is on [67] the date that she was there on the 8th of November and this is the second time she was in,

11/10/79, and it says, "saline injection performed without any complications and percodan."

* * * * * * *

Q. The marking, ma'am, on the Remarks portion, that has to do only with the visit on the 8th. Is that correct?

A. Yes.

Q. And the Diagnosis would have been made at the same time? Is that normal procedure?

A. Yes. That's what was written the first time she was there.

Q. So then the 10th, you have the date in and that's what happens on the 10th?

A. Yes.

* * * * * * *

[68] CROSS EXAMINATION

BY MR. LUCAS:

Q. Ms. Karageorges, do you have the initial contact with a patient who calls the American Women's Clinic?

A. All days but one.

Q. Do you recall talking with Patty McDonald?

A. I took care of any arrangements to be made on saline abortions.

Q. Do you generally tell the patients that they can go to the hospital for the injection?

A. Yes, I do.

* * * * * * * *

A. It was Patricia McDonald that called and she was -- she told me that she was pregnant approximately [69] five months

and I told her that -- and she was seeking an abortion.

I explained to her what the arrangements would be in order for her to have a saline abortion. I told her that she would have to have an injection and at the time of delivery of the fetus she would have to go to the hospital, Fairfax Hospital, as a matter of fact.

Q. Do you recall when she came in to the clinic?

A. Yes.

Q. Do you recall both occasions that she came in?

A. Yes. I was present both times.

Q. Did you participate in giving her any kind of general explanation of the procedure?

A. I did this when I spoke with her on the phone when we made the appointment for her to come in and I had told her that she would have to come in and be examined and evaluated by the doctor and then she, you know, she would discuss any details with the doctor himself.

When she came in, I gave her the chart. She filled in the information. I knew what she was there for.

The doctor did examine her and then she came [70] to my desk, you know, to pay and then to make further arrangements. I told her again what the procedure is, that she can have the injection and later go into the hospital to abort.

Q. Did you give her at some point in time a sheet of paper called Post-Injection

information which I think is Exhibit 3?

A. That was the third time -- well, the second time that she visited the clinic. At the time of the saline injection itself, yes, I did.

* * * * * * * *

Q. At what point did you say you gave her a copy of that?

[71] A. When she came in on Saturday, the 10th.

Q. Was her boy friend present at the time you gave her those instructions?

A. He came in with her both days.

Q. Do you recall whether he was nearby at the point you gave those to her or explained them to her?

A. They were together at all times

except for the time she was in the operating room, you know, the treatment table.

Q. Did you at any time tell her she had to go to the hospital for expulsion of the fetus?

A. Yes, I did, at all times that I spoke with her.

Q. How many times did you tell her that during the course of your different meetings with her?

A. Quite a few times. I told her that over the phone and then when she made arrangements to come back on Saturday for the injection. I told her what she would have to do and also the next time that I stressed this was when she had the injection and she was standing there with her boy friend.

I told her and her boy friend also. They were standing in the hallway on their way out.

Q. Is this something you repeatedly stressed to her?

[72] I do with every case, sir.

Q. Did Patty McDonald leave the instructions anywhere or attempt to leave the instructions anywhere, to your knowledge, at the time she was at the clinic?

A. She left it somewhere in the operating room when she went in because the nurse came back out with them to hand them back to her on her way out, and that was Mrs. Weiss.

Q. Do you recall shortly before she left, after the injection, the boy friend nodding in any way while you were explain-

ing that she should go to the hospital?

A. Yes. I explained it further to him because they were standing there together. You know, he was holding her and I was telling him what the instructions were also, in case, you know, that he would be present whenever anything happened. I didn't know what their plans would be.

Q. Did you receive any indication of where they might be going in the meantime?

A. No, I did not.

Q. Do you even know where the Howard Johnson's Springfield Hotel is?

A. No.

[73] Q. Did you at any time overhear Doctor Simopoulos tell the patient about meeting her at the hospital?

A. Yes, sir. He was in the operating room. I was present in the operating room along with the nurse and the doctor. I heard him, you know, tell her after the injection was over, I heard him tell her that if she has any signs of labor, to call him and meet him at the hospital, Fairfax.

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REDIRECT EXAMINATION

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[74] Q. On the 10th, were you in there while the procedure was done?

A. Yes, I was.

Q. While the saline was actually being administered?

A. Uh-huh, yes.

Q. Did she have any conversation

with Doctor Simopoulos on that day concerning where she was going?

A. Where she was going, no.

Q. And you were present during the entire procedure?

A. Most of it. I was absent for the first few minutes. I was outside on my desk, at my desk.

Q. And who remained with her after the procedure was done on her?

A. We were all there; the doctor, the nurse and myself.

Q. While you were out at your desk, who was there?

A. This was when she went in to get undressed and ready that I was not there and the nurse and the doctor were in the room.

* * * * * * *

[76] Q. I show you this item marked Commonwealth's Exhibit No. 10 for identification and ask you if you can identify that.

* * * * * * *

Q. Do you know what that is, ma'am?

(Handing item to witness.)

A. A brochure describing the services of the American Women's Clinic.

Q. Have you ever seen that before?

[77] A. Yes.

Q. Have you ever seen others like it before?

A. At the office, yes.

Q. Is that a handout that you have in the office?

A. No. I don't hand them out.

Q. Where are they kept in the office?

A. In a box in the closet.

Q. Do they stay in the box in the closet?

A. Yes. They have been there for quite awhile now.

Q. How about in the waiting room?

A. I don't know if I have any there.

Q. You don't keep them in the waiting room?

A. I don't think I do, but I'm not sure.

Q. What are they used for?

A. They were mailed to medical offices and institutions as a reference to our clinic and our services.

Q. As an advertisement so to speak?

A. Yes.

* * * * * * *

[79] RECROSS EXAMINATION

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Q. For the purpose of testifying for the defense, did Detective Warner or Dooley or any of the other people who came to the clinic say anything about making charges on the basis of not having the consent of the minor?

A. Well, when they came to arrest Doctor Simopoulos and they took him, you know, in a hurry, I just, you know, [80] didn't know what was going on and once Doctor Simopoulos was out of the building, I asked either Detective Dooley or Warner, I don't remember who, why, you know, what was happening and he said he is arrested for -- he is being arrested for doing an illegal abortion on a minor.

I questioned it. I said, "why on a minor?" He said, "he didn't have parental consent." I said, "I didn't know you had to have it." He says, "well, that's the law."

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[83] PATRICIA MCDONALD,

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DIRECT EXAMINATION

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Q. State your full name, please.

A. Patricia Anne McDonald.

Q. What is your age?

A. Eighteen.

[84] Q. When did you turn 18?

A. December 21st.

Q. 1979?

A. Uh-huh.

Q. Where do you live?

A. Woodbridge.

Q. Woodbridge, Virginia?

A. Uh-huh.

Q. Directing your attention to Thursday, November 8th, 1979, did you have occasion to go to the location at 916 West Broad Street in the City of Falls Church?

A. Yes.

Q. Could you tell the Judge what is at that location.

A. It's a women's clinic.

Q. Is that also the office of Doctor Simopoulos?

A. Yes.

Q. What was the reason for your going there?

A. To have an abortion.

Q. Had you made any arrangements ahead of time to go there on that particular day?

A. I called and made an appointment.

Q. What time was your appointment on the 8th of November?

[85] A. 9:15 or something like that.

Q. In the morning?

A. Yeah.

Q. Tell the Judge what you did when you first got there.

A. I signed-in in the book and I waited in the waiting room. Then I went in to one of the rooms and had an examination.

Q. Did you fill out any forms while you were there?

A. Two.

Q. What was the nature of those forms?

A. One of them was just -- it was like a medical history, but it's just a little bit of it. The other one was just general information.

Q. I show you this exhibit that's marked Commonwealth's Exhibit No. 9.

Are those the forms you are referring to?

A. Yes.

Q. The one on the left hand-side of the folder, did you fill that one out?

A. Yes.

Q. The registration slip?

A. (Nodding head.)

[86] Q. How about the yellow sheet?

A. Yes.

Q. Which part of that did you do?

A. Just the top part.

Q. Is this green notebook the one that you signed in?

A. Yes.

Q. Did you sign-in both times you went there?

A. Yes.

Q. Now, when you went into the examining room, tell the Judge what happened.

A. He examined me.

Q. Who examined you at that time?

A. The doctor.

Q. Do you see him in the Courtoom?

A. Yes.

Q. Where is he seated?

A. Back there. (Indicating)

Q. The gentleman at the rail?

A. Yes.

MR. HORAN: Let the record show that she has indicated the Defendant.

BY MR. HORAN:

[87] Q. Tell His Honor what the examination was.

A. It was just a pelvic examination.

Q. Did he ask you whether or not you were pregnant?

A. Yes.

Q. What if anything did you tell him?

A. I told him I was about 22 weeks pregnant.

Q. Did you have any other discussion with him on that day?

A. Yes. He just asked me if I went to school and I told him yes, and he asked me if my parents knew about it and I told him no. He asked me what I was going to do, where I was going to go and I told him a motel. He said it was okay. It was possible to do it at home.

Q. Did he explain to you at all what procedure would be followed?

A. He just said saline solution.

Q. Did you know what that was?

A. I knew it was an injection, but that's all.

Q. How long did you remain in his office all together on the 8th of November?

A. Around 15 to 30 minutes.

Q. Did you make an appointment to go back again?

A. Yes.

[88] Q. What was the date of the second appointment?

A. The 10th.

Q. Was that on Saturday?

A. Yes.

Q. Who did you make the arrangements for the Saturday appointment?

A. The receptionist.

Q. What time were you to be there on Saturday?

A. Around 11:00.

Q. Did you in fact go there at 11:00 on Saturday?

A. Yes.

Q. Tell the Judge what happened when you got there that day.

A. Then I signed in again, and then

we went -- it was like a little operating room, and then he did it.

Q. You said he did it. Who are you talking about?

A. The doctor.

Q. Would you tell His Honor specifically what was done.

A. Okay. He put some yellow stuff on my stomach. Then he injected the saline solution.

Q. Into what part of your body was that injected?

A. My stomach.

[89] Q. Then what happened?

A. After that, that was about it.

Q. Who was present while that was done?

A. Just the doctor and the nurse.

Q. How long did you remain after the injection was done?

A. After it was done, I just got dressed and paid and left.

Q. Right after it was finished?

A. It might have been about five minutes later.

Q. Where did you go when you came out of the operating room?

A. To the front hallway to pay.

Q. Who did you pay?

A. The receptionist.

Q. How much did you pay?

A. $475.

Q. Did you have any conversation with the receptionist?

A. No. She just gave me the post-operative instructions and told me to read

them and a prescription.

Q. When was that first given to you?

A. Right after it was done.

[90] Q. Had you ever seen that sheet before then?

A. No.

Q. Now, I show you this. It's marked Commonwealth's Exhibit No. 6. Is that the sheet that you are referring to?

(Handing item to witness.)

A. Yes.

Q. Now, did you read that at all while you were in the doctor's office?

A. Not in the doctor's office. I read it later.

Q. Where did you go from the doctor's office?

A. To a motel.

* * * * * * *

[91] Q. Approximately what time did you arrive at the motel?

A. About two.

Q. Who was with you?

A. Just my boy friend.

Q. Had he been with you when you went to the doctor's office earlier that day?

A. Yes.

Q. Did he remain at the doctor's office while you [92] were there that day?

A. Yes.

Q. Was he ever in the operating room with you?

A. No.

Q. You went to the motel and arrived about 2:00 in the afternoon?

A. Yes.

Q. How long did you remain in that motel?

A. Until about 12:00 Monday.

Q. Was your boy friend with you there part of that time?

A. Yes.

Q. Can you approximate how long he was there with you on Saturday?

A. Until about 3:00 in the morning.

Q. How about on Sunday?

A. He came about 12 and then left about 10:00 that night.

Q. Did there come a time when you went into labor?

A. Yes.

Q. When did that occur?

A. It was about Monday morning or Sunday night about 12, 1:00.

[93] Q. Was anybody there with you when that happened?

A. No.

Q. Did there come a time when you delivered?

A. Yes.

Q. Approximately what time of day was that?

A. About 11:00 Monday.

Q. Was anybody with you when that occurred?

A. No.

Q. Where did that take place?

A. In the hotel room.

Q. Any specific part of the motel room?

A. In the bathroom.

Q. And did you deliver that child?

A. Yes.

Q. What did you do with it?

A. I left it in the motel.

Q. Whereabouts?

A. In the bathroom.

Q. Had anybody told you ahead of time what that delivery would be like?

A. No.

Q. Had you been advised at all by the doctor as to what to expect at the time of delivery?

[94] A. No.

MR. HORAN: I have no further questions, Your Honor.

THE COURT: Cross examination.

CROSS EXAMINATION

BY MR. LUCAS:

Q. Ms. McDonald, around what time did

you have the actual abortion in the motel? What time of day?

A. About 11:00.

Q. And you did not telephone Doctor Simopoulos around that time at all?

A. No.

Q. In fact, he didn't even know you were there as far as you know, did he?

A. No.

Q. Did you call him at any time that you were there?

A. No.

Q. Did you tell us at the preliminary hearing that you didn't call anyone?

A. Yes.

Q. Is that true?

A. Yes.

Q. You made no phone calls whatsoever

when you [95] were in the motel?

A. No.

Q. Do you have the receipt from the bill at the motel?

A. Not any more.

Q. Not any more. If I showed you that receipt, would it have any record of phone calls being made from the hotel?

A. It does have a record, yes.

Q. So you did make some phone calls?

A. No, I did not. It was a mistake on their part.

* * * * * * * *

[98] Q. At the time you went to Doctor Simopoulos' office, did you go there thinking you were going to have an injection of saline solution?

A. Yes. They told me over the tele-

phone that's what it would be.

Q. Didn't they tell you you were not going to abort there specifically?

A. They really never mentioned that fact.

Q. Did you ask?

A. No.

Q. Nobody suggested you were about to abort there, did they?

A. No.

Q. When you left Doctor Simopoulos' office, did you know where you were going to abort?

[99] A. I knew where I was going.

Q. But you didn't even know at that time that you left that you were going to abort, did you?

A. Well, I figured I would stay there

until it happened.

Q. You said you filled out some forms there. Did you fill out a history and consent form?

A. I don't know what it was called.

Q. When you first called Doctor Simopoulos' facility, had you totally made up your mind that you wanted to obtain an abortion procedure?

A. Yes.

Q. Do you recall calling any other hospitals or clinics or anybody else?

A. I called a few to find out about the prices.

Q. What did you find out about the prices at other places?

A. That they all ran about the same or higher.

Q. Did you call any first trimester clinics?

A. I have no idea.

Q. You said you didn't call any hospitals at all?

A. No.

Q. When you came into the clinic, what was your [100] state of mind? Were you depressed at all?

A. No.

Q. You didn't behave in a depressed manner when you first came into the clinic?

A. No.

Q. You weren't upset about the pregnancy at all?

A. Scared, but nothing else.

Q. Were you concerned about your

parents finding out?

A. Yes.

Q. Did you tell anybody at the clinic that you didn't want your parents to find out?

A. Yes.

Q. You said Doctor Simopoulos said something about -- I will withdraw the question.

When you first came in, is that when you told him about your parents, not wanting your parents to know?

A. Yes.

Q. You said that Doctor Simopoulos said something about your aborting at home. Was this after you told him you didn't want your parents to know?

A. Yes.

Q. Did you repeat then that I couldn't do that [101] because I want my parents not to know?

A. He didn't mean at home. He meant not in a hospital, like a motel room like I had told him.

Q. He never told you to ignore the follow-up instructions though, did he?

A. No.

Q. And didn't the receptionist tell you to follow the follow-up instructions carefully?

A. She just said read them.

Q. How many times did you read them before you aborted?

A. Once.

Q. Where were you then?

A. Probably in the car.

Q. You didn't read them before you left the clinic?

A. I didn't have enough time. I just got them and left.

Q. You didn't tell anybody at the clinic that you read them before you left?

A. No.

Q. Was your boy friend with you during any of the explanations --

A. No.

[102] Q. -- at the clinic. Never was standing beside you?

A. No.

Q. He was never standing there nodding his head when people were giving you follow-up instructions?

A. Well, there were instructions, but no, he wasn't with me.

* * * * * * *

[103] Q. Where did you keep the follow-up instructions while you were at the motel?

A. On a table.

Q. Did you take any medication or anything while you were there?

A. I had a prescription for percodan.

Q. How much of that did you take?

A. About eight pills.

Q. Excuse me.

A. Eight.

Q. Did you eat anything while you were there?

A. I had some peanut butter and jelly sandwiches.

Q. Did you smoke anything while you were there?

A. Cigarettes.

Q. Where did you leave the follow-up instructions?

A. On a table.

Q. You didn't leave the follow-up instructions in the bag with the fetus?

A. I might have thrown them away.

* * * * * * *

[104] Q. What people did you meet with at that time?

A. Investigator Dooley and someone from Prince William County and someone from another County.

Q. Who were the other people with Investigator Dooley?

A. I have no idea.

Q. How many people were there?

A. There were four all together.

Q. Did they tell you that you were under investigation or anything?

A. I think when they first came to the door, they told me they wanted to talk to me about what had happened, yes.

* * * * * * * *

[105] Q. Do you have any motive to harm Doctor Simopoulos?

A. The way it's explained to me is he is harming more people.

Q. Who made this explanation to you?

A. I think that I didn't know nothing that was going to happen to me and I think that's pretty bad.

Q. You didn't know anything about what labor was?

A. I knew it hurt, but I didn't know nothing that [106] was going to happen

there.

Q. But you never asked anybody for any more details than you already were given in the explanation, were you?

A. No one ever told me.

Q. Did you ask any further questions?

A. No.

Q. Did they ever refuse to answer any questions that you asked?

A. No, but I think they could have explained it to me.

Q. The whole time you were there, you never called in for any further information or anything like that?

A. No. What I thought it was going to be, it wasn't.

Q. Did you tell them what you thought it was going to be?

A. No.

Q. Do you think they could read your mind in any way?

A. No, but could I read theirs?

Q. At any time did you consider going to the hospital?

A. Only if I would have had to have the baby.

[107] Q. After you were in the motel, at any time did you consider going to the hospital?

A. No.

Q. You basically ignored the follow-up instructions. Isn't that true?

A. Well, I thought it was pretty strange that they said that when he told me something different.

Q. But you already told us he didn't

tell you to disregard the follow-up instructions.

A. No, but he told me that it was possible that I didn't have to go to a hospital.

Q. You didn't misunderstand him in explaining that people can deliver in different places?

A. No, I did not.

Q. You didn't call him for any clarification, did you?

A. He told me it more than once. It was pretty clear to me at the time.

* * * * * * *

[108] Q. Who was present with you when Doctor Simopoulos gave you any instructions?

A. He never gave me any instruc-

tions. The only thing I got was what the receptionist gave me, that sheet, and no one was with me.

Q. He never gave you any instructions. That's your testimony. He certainly didn't give you instructions to abort at the motel, did he?

A. He told me it was possible, that I did not have to go to a hospital.

Q. Did he say it was possible that people sometimes abort before they got to the hospital?

A. That's not what he meant.

Q. You are reading his mind?

A. That is not what he said and it is not what he meant. He made it perfectly clear what he meant.

Q. And you never once questioned

that being inconsistent with the post-operative instructions?

A. I read the instructions after I left.

[109] Q. Didn't you try to leave the instructions in the clinic and ignore them completely?

A. That was an accident. I forgot about them. I also left the prescription at the same time.

* * * * * * * *

Q. Did the receptionist, as you were leaving, instruct you any further on the follow-up instructions?

A. Just to read them.

Q. Did you say to her, well, Doctor Simopoulos told me I could abort in the motel or somewhere like that? Why should

I read them?

Did you say that to her?

A. No.

Q. When she told you to read them, did your boy friend nod that he was in agreement with following those instructions?

A. He wasn't even listening. He was in the waiting room.

[110] Q. Do you recall at all Doctor Simopoulos saying to you that he would meet you at the hospital after your contractions started?

A. No.

Q. You absolutely deny that he said that to you?

A. Yes.

Q. Is there any reason why you left

the fetus in the motel?

A. Because I did not know what to do with it. I was scared.

Q. You still had Doctor Simopoulos' phone number. Why didn't you call him?

A. Because I was scared and I was hurting and I just wanted to go home and I was in shock because no one ever told me that was going to happen.

Q. When you were in the motel, you never re-read the post-injection information?

A. No.

Q. To find out specifically what to do the whole time you were there?

A. No.

Q. You didn't read things that the post-injection information said about hav-

ing a miniature labor or [111] anything like that?

* * * * * * * *

Q. When you aborted, you expelled a fetus in the motel, correct?

A. Yes.

Q. Didn't anybody tell you that's what was going to happen?

A. No.

Q. Doesn't it say that right there on the post-injection sheet that the fetus will be expelled?

A. He told me in the hospital that the fetus was destroyed. I thought that meant it was just going to be like a miscarriage and that was all.

Q. Isn't that exactly what it was like, a miscarriage?

A. A miscarriage is just blood.

Q. You don't think a miscarriage also includes a fetus?

A. It might, but what I thought it was going to be was just blood.

Q. You knew you were 22 weeks pregnant, didn't you?

[112] A. Yes, I was the one that told him.

Q. Did you indicate to us earlier today that you had known that you were pregnant for over 16 weeks?

A. Well, it's a little easy to tell, yes.

* * * * * * * *

Q. Did your boy friend come back to meet you at the motel to take you home at any prearranged time?

A. He came back that Monday around

12:00, yes.

* * * * * * * *

Q. When you left the motel, you wanted to go directly home?

A. Yes.

Q. Did you feel there was no need to go to a hospital or anything like that at that time?

A. No.

Q. You haven't needed to go to a hospital since that time?

[113] A. I went to a hospital.

Q. That was at the police officer's suggestion?

A. Yes.

Q. Do you recall who the physician was you met with?

A. No.

Q. Did you discuss any of your medical history with the physician at all?

A. They had it all on records. It's a military hospital.

Q. What department did you go into?

A. Gynecology.

Q. Was it a physician you had ever seen before?

A. No.

Q. You have refused to be interviewed by the attorneys in my office, haven't you?

A. That's right.

* * * * * * *

[114] Q. Ms. McDonald, did you ever at any time discuss those follow-up instructions with Doctor Simopoulos?

A. No.

Q. Where did you get the percodan from that you used over that weekend?

A. From a prescription at People's Drug.

Q. Who gave you that prescription?

A. The doctor.

* * * * * * *

[118] MOTION TO STRIKE

MR. LUCAS: May it please the Court, Your Honor, the Defendant respectfully moves the Court to strike the Commonwealth's case on the grounds that there has been insufficient evidence presented on which a reasonable person could find beyond a reasonable doubt that all the elements of the alleged offense have been proved.

* * * * * * *

[120] All the gynecologists that took the Stand here had had unfortunate experiences of patients disregarding their instructions. There is no control over this patient when she left there and apparently determined to go to the motel.

The motel is not anywhere near Doctor Simopoulos' clinic. It's not even anywhere near that area.

The State also fails further on this question of causation and that is the biggest absence in the State's case.

Perhaps one of the reasons that we had all of our witnesses starting tomorrow is we had assumed the State was going to put on some expert testimony on this issue of medical causation. There has been no testimony on causation.

The only physician who testified for the State, Doctor Wiecking, admitted that he could not testify that there was any causation of the saline injection causing the abortion. He flatly admitted that. [121] He was not even asked any hypothetical questions to try to tie in the so called circumstantial evidence. He was never even asked the questions that would have possibly given him the opportunity to put in some kind of evidence of even a worse circumstantial nature of causation, but in fact his testimony expressly denied any causation.

There has been no other medical person on that Stand who could testify to causation. That element totally fails. It would have required some proof of what type

of saline solution was put in, was this enough to cause an abortion, was the fetus examined to show whether the saline injection caused the abortion. Absolutely no evidence even attempted on that and the total failure of proof on the causation.

I think Patty McDonald's suggestions or implications are not worthy of belief that she was told to go to a motel. There is no reason on earth why Doctor Simopoulos would tell a patient to go abort in a motel that he didn't even know where it was located, and not even located near his clinic.

There is no motive for him whatsoever for him to have her abort outside of a hospital when he gave her [122] follow-up instructions to abort in the hospital and

when he, according to testimony from other witnesses, told her and they told her and the follow-up instructions told her to call when cramping began and go to the hospital.

There is no suggestion whatsoever.

Lastly, the Commonwealth has certainly presented no further medical testimony, no further expert testimony to tie in any of the essential elements of the offense.

To find a possibility of determining guilt beyond a reasonable doubt in a situation like this would require totally ignoring the absence of causation and totally ignoring the absence of any proof on the subject of intent.

We therefore submit that the Court should strike the Commonwealth's case and dismiss the Indictment and we further re-

new the other motions that we have made to the Court earlier in the day.

THE COURT: Mr. Lucas, when 18.2--73 says, "provided such procedure is performed in a licensed hospital," what procedure do you think that is referring to?

MR. LUCAS: I think it definitely refers to an abortion. It's ambiguous, perhaps, but I think if [123] it doesn't, if it's not clearer than that, I think the Legislature has the obligation to make it clear, but I think that such procedure has to refer to the abortion.

THE COURT: It has to refer to attempt to terminate a human pregnancy or aid or assist in a termination of a human pregnancy.

MR. LUCAS: It could conceivably be

read that way.

THE COURT: Or causing a miscarriage. Those are the only things that antecede it.

MR. LUCAS: The only procedure, though, is the miscarriage.

THE COURT: Causing a miscarriage.

MR. LUCAS: Here there is no proof of causation.

THE COURT: What causes the miscarriage? The injection of saline solution.

MR. LUCAS: There has been no proof of that. One of our witnesses, one of the witnesses testified that in order for the saline injection to cause a miscarriage, that was not all of the cases and it had to be a certain amount of saline solution entered in a particular way. There has been no testimony whatsoever [124] con-

cerning the amount of saline that was put in.

One of the studies that we had showed that for a certain period of time they had accidentally been putting in a solution they thought was saline solution and it didn't have any saline and the people weren't aborting.

But there is no proof and it is incumbent upon the prosecution to prove beyond a reasonable doubt that something was --

THE COURT: I will deny your motion to strike in that the circumstantial evidence is at least incredibly strong that this fetus was aborted as a result of the saline solution. That's the purpose of it.

MR. LUCAS: The Medical Examiner certainly was not willing to go that far and

he is a medical person that has examined fetuses before.

The Commonwealth in this case and its investigation simply has not -- if they could have dug up any proof which one doesn't know, that's not even attempted, they didn't ask hypothetical questions based on the circumstantial evidence. They didn't even ask the questions to the Medical Examiner.

THE COURT: Patty McDonald went in there to have an abortion. Your client said he was doing an [125] abortion. She paid for an abortion.

He gives her the saline solution and she aborts. He tells the officer at a later time that he performed an abortion. That's pretty strong evidence that that's

what caused the abortion.

MR. LUCAS: But, Judge, if she hadn't aborted the fetus, could he have been prosecuted? If he had tried to drag her to the hospital and she had gotten away, could he have been prosecuted?

Those situations aren't really any different from the situation we have here.

THE COURT: I'm not saying that he couldn't be prosecuted if he had made the injection in a hospital and she aborted in a motel room.

What I am saying, though, is that in my opinion this Statute, in unambiguous language, requires hin to make that saline injection in a licensed hospital.

All of the evidence is, by stipulation, his clinic is not a licensed

hospital.

MR. LUCAS: Your Honor, we would also ask the Court to reconsider the various motions that we had filed. I think the further testimony, since the argument of the motions, has further shown the ambiguity of the [126] Statute, the witness after witness referring to the procedure and the abortion as being the patient delivering as opposed to the injection, I think, has shown this is an unusual application by the prosectuion of a Statute which is simply not clear and could be much clearer.

THE COURT: Well, I disagree with you on that. I think any educated person reading the Statute, it's as clear as a bell. It says, "use means with intent to destroy

an unborn child."

It exempts the doctor if those means, such procedure is performed in a licensed hospital. I don't know what else it can mean. The abortion itself certainly isn't a procedure.

MR. LUCAS: I think it actually is, the procedure of delivering, the procedure of aborting.

THE COURT: That's not in my opinion what this Statute means. I think it is unambiguous.

* * * * * * *

Commonwealth's Exhibit 6

is the same as

Defendant's Exhibit 3

Commonwealth's Exhibit 7

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH
OFFICE OF THE CHIEF MEDICAL EXAMINER

NORTHERN VA. DISTRICT
THE FAIRFAX HOSPITAL
P. O. BOX 2256
FALLS CHURCH, VIRGINIA 22042

REPORT OF AUTOPSY

Autopsy No. NV-805-79
Date 11-12-79
Time 1540

Decedent Fetus from Howard Johnson's at Springfield

Autopsy Authorized by: Dr. Cooper - Fairfax
Body Identified by: Inv. Dooley - Fairfax Police Dept.
Persons Present at Autopsy: Inv. Dooley, Dr. Cooper, Beyer, Dr. Enos Dr. Wiecking

Rigor: complete_____jaw_____neck_____
arms_____legs_____
Livor (sic): color_____distribution:

Age _____Race_____Sex_____Length_____
Weight_____Eyes_____Pupils_____
R_____
Hair_____Mustache_____Beard_____
Circumcised_____Body Heat_____

Clothing, Personal Effects; External

wounds, scars, tattoos, other identifying features:

Immature fetus with attached placenta in paper bag containing artifacts from trash can at Howard Johnson's, see list of Inv. Dooley for complete contents; included are: People's Drug Store #191 prescription envelope 1194725 (11-10-79). RX. #334003 and a mimeographed paper entitled "Post Injection Information" from
PATHOLOGICAL DIAGNOSES
Chris Simopoulous(sic), M.D., FACOG
(703-491-3366, 703-550-9387).

Immature male fetus, 28 cm. crown-heel length, 495 gm., with attached cord and placenta (estimated gestational age 5½ months).

Cause of Death: Immaturity

Provisional Report_____
Final Report xx 11/23/79

The facts stated herein are true and correct to the best of my knowledge and belief.

Date Signed 23 Nov 79
Place of Autopsy Fairfax Hospital
Signature of Pathology s/David K. Wiecking, M.D.
January 14, 1980
s/ L. E. Beyda

GROSS DESCRIPTION

SKIN:
SEROUS CAVITIES:
PLEURA:
PERITONEUM:
HEARD:
HEART:
AORTA:
LUNGS:

Immature male fetus with attached cord and placenta; measures 28 cm. crown to heel. Fetus weights 495 gm. grossly normally formed externally and internally. internal organs in normal anatomic arrangements and status of development for size. lungs immature and sink rapidly in water; cord and placenta grossly normal.

LIVER:

GALLBLADDER:

SPLEEN:
PANCREAS:
ADRENAL GLANDS:
G.I. TRACT:

KIDNEYS:

BLADDER:
EXTERNAL GENITALIA:

NECK ORGANS:

BRAIN AND MENINGES:

SKULL:

VERTEBRAE:

RIBS:

PELVIS
EXTREMITIES:

OTHER LABORATORY PROCEDURES: TOXICOLOGY☐
BACTERIOLOGY☐ DENTAL CHART ☐
X-RAY☐ FINGER-PRINT☐
PHOTOGRAPHY☐ SEROLOGY☐ FORENSIC
SCIENCE☐

DISPOSITION OF EVIDENCE

TYPE (clothing, Bullets, Etc.)
NAME OF RECIPIENT
ADDRESS
OFFICIAL TITLE
DATE

Commonwealth's Exhibit 9

- Original in Record

Commonwealth's Exhibit 14

AMERICAN WOMEN'S CLINIC

CONSENT TO ABORTION

I _____ do hereby authorize and consent to Dr. _____ to terminate my pregnancy by the performance of an abortion or by causing a miscarriage. I am less than 12 weeks pregnant and have not been given any guarantees of the outcome of the abortion. Furthermore, I realize that it is my responsibility to return to the clinic within 72 hours from the time of the abortion in order to receive the Rho-Gam injection, if my blood is Rh (-) negative.

The operation consists of a routine pelvic examination followed by a cleansing of the vagina with an iodine solution with a soft cotton swab. A local anesthetic will be injected along the sides of the cervix - entrance to the uterus (womb), if desired. This will lessen cramping sensations noted when the cervix is dilated (stetched) (sic). A small tube (the size of a pen) is passed through the vagina into the uterus after the cervix has been dilated. The contents of the uterus are removed by suction. A metal oval scraper (curette) may also be follwing (sic) the vacuum aspiration.

I understand that there is a low risk of:

infection; failure to interrupt the pregnancy; perforation of the uterus; possible damage to the intestine; heavy bleeding; subsequent higher rate of miscarriages; and delay of my next period. I am also aware of the dangers and low risks associated with continuance of this pregnancy and delivery.

I have been advised not to have sexual intercourse, to douche, or to use tampons for the next two weeks following the abortions,(sic) and within two weeks I should have a follow-up pelvic examination at no extra charge. If fever with or without chills, lower abdominal or pelvic pains, or heavy bleeding persists, I will contact this office or see a physician immediately. I shall rest at home at least three days to lessen bleeding and discomfort. If necessary, I may be given a prescription for pain and/or an antibiotic.

Under Federal and Virginia law, a married woman does not need her husband's consent to have an abortion. The Supreme Court decision in July of 1976 permits minors to have an abortion without parental consent.

The abortion will be performed in strict confidence. No information will be released (not even to my husband) without my written permission.

The nature and purpose of the operation, possible alternative methods of treatment,

the risks involved, the possible consequences, and the possibility of complications have been explained to me by Dr. _____ and, by his assistants. I understand the explanation and I acknowledge that should this procedure produce a viable child, that the child shall be the responsibility of the patient.

Signature: _____ Date: _____

Address: _____ Time: _____

_____

VIRGINIA:

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

----------x

COMMONWEALTH OF VIRGINIA, :

-vs- :

CHRIS SIMOPOULOS, :

Defendant. :

----------x

Criminal Docket No. 30906

Circuit Courtrooms 8 and 4
Fairfax County Courthouse
Fairfax, Virginia

Wednesday, April 16, 1980

The above-entitled matter came on for trial before THE HONORABLE F. BRUCE BACH, Judge, in and for the Circuit Court of Fairfax County, Virginia, at 10:00 o'clock a.m.

* * * * * * *

[2] DOCTOR PETER SOYSTER,

* * * * * * *

DIRECT EXAMINATION

* * * * * * *

[3] Q. When were you first licensed to practice in the Commonwealth of Virginia?

A. 1951.

Q. Do you hold Board certification in the OB/GYN field?

A. Yes, sir.

* * * * * * *

A. I am an Associate Clinical Professor in obstetrics and gynecology at George Washington University.

Q. What proportion of your time is involved in private practice now?

A. Probably 90 percent.

Q. Has your private practice included

the full range of obstetrics and gynecology?

[4] A. Yes, sir.

Q. At some time has that practice included the termination of pregnancies by saline instillation?

A. Yes, sir.

Q. Did you ever do saline instillation procedures on an outpatient basis?

A. I did.

Q. Could you describe to us where the procedures were done and where the pregnancies were terminated.

A. I did the saline solution instillation in the hospital as an outpatient procedure, discharged the patient and most of them then remained at home when the pregnancy aborted and returned to my office for examination at that time or the following

day. Some of them were readmitted to the hospital.

Q. Approximately how many such patients did you see over the time that you did these procedures?

A. I don't have any accurate count of it. I have not made any effort to keep a record of the total number, but over the period of time that I was doing them from the early 1960's until probably about 1970, '72, very likely fewer than 100.

Q. Could you describe the type of room in which you [5] injected saline in your experience and practice. What hospital was this at?

A. At Fairfax Hospital. Initially, when we first started doing them, probably 1961, 1962, someplace in there, just in

the patient's room, her regular hospital room.

The same practice was followed at George Washington University Hospital.

Q. Did you have any kind of special equipment in the patient's room?

A. Only the equipment for performing the procedure.

Q. What would this include?

A. A needle, a syringe, local anesthetic, a bottle of 20 percent saline solution.

Q. From your understanding of the practices of OB/GYN at Fairfax Hospital at that time, was that pretty much the standard practicing procedure?

A. Yes, sir.

Q. Was it also the standard practice

and procedure for the patients to abort at home?

A. I am not certain that a majority did do that. Certainly, in sizable number and it may have been a majority. It was easily 30, 40 percent and perhaps [6] more than 50.

Q. How did the setup there compare with the setup that Doctor Simopoulos has now, if you have seen his facilities?

A. In his office?

Q. Yes.

A. His facilities are certainly much more elaborate than we had available at that time.

Q. Have you had occasion to become familiar with the Fairfax Hospital policy on second trimester abortions?

A. Yes, sir.

Q. Does that policy require parental consent for people under 18?

A. Yes, sir.

Q. Would it be possible for a patient to avoid the parental consent requirement if she came into the emergency room aborting or not?

A. It would certainly seem so to me because then she has a medical situation which is in progress.

Q. If she were admitted to the hospital as an inpatient, is there any legitimate means of avoiding the parental consent requirement for a second trimester abortion patient who is under 18?

[7] A. Prior to the instillation of the saline solution?

Q. Yes, sir. At the present time.

A. I would think not as the Department regulations did require that.

* * * * * * *

[8] Q. Is the, in medical practice, is the injection of saline solution considered an abortion procedure?

A. No, sir.

Q. Is the delivery of a fetus by a physician in any kind of facility considered a medical procedure?

A. The delivery of a fetus would be, in a sense, a medical procedure to the extent that the physician [9] participates in it. Obviously, it's also a biological function which the pregnant woman participates in.

Q. In looking at that law as a

physician, do you see any uncertainty in it? Do you see any difficulty?

Do you have any difficulties in interpreting whether it permits a saline injection to take place outside of the hospital?

A. To me, it would be a little difficult to ascertain because in a medical sense an abortion is a process that occurs over a period of time. I suppose it would be possible that the law does require that the woman be confined to the hospital start to finish.

It's a little unreasonable and unnecessary, a medical opinion, but perhaps that's a requirement, but if that is not, then I really wouldn't be certain whether it would specifically require that,

the saline injection, because it is an attempt to induce an abortion, would necessarily have to be in the hospital or that the patient would undergo the actual process of the abortion in the hospital.

Again, I don't know.

Q. Can you tell from looking at this clause whether or not the delivery of the fetus is something [10] that would have to be done in the hospital? Is that clear at all?

A. Not in a literal sense, no, sir.

Q. In practicing OB/GYN with second trimester patients, can you exercise absolute control over their whereabouts and the time at which they abort?

A. No, sir.

Q. Have you had experiences with

patients aborting in unusual places at unusual times?

* * * * * * *

Q. Referring to the process of saline injection, when you have had a saline injection, does that always cause a patient to abort the fetus?

A. No, sir.

Q. In what proportion of cases does no abortion take place?

[11] A. Perhaps 10 percent, 5, 10, 15, in that range.

Q. When you take a specific case of a specific patient who had a saline injection and who subsequently in time did abort the fetus, can you tell whether the saline injection caused the fetus to abort without doing any special tests on the

fetus?

A. Without doing any special tests?

Q. Any special tests on the fetus.

A. No, sir.

* * * * * * *

Q. Are you familiar with studies and research on the mechanism of the impact of saline injection on a fetus?

A. It does cause a marked dehydration of the fetus, [12] hypernatremia, lower concentration of sodium in the fetus. It causes the central nervous system to damage in the fetus which is detectable microscopically and sometimes grossly.

Q. In some cases those things are not caused, though. Is that correct?

A. Sometimes not.

Q. Without performing tests on the

fetus, would you just be speculating as to the cause of death?

A. I suppose you would.

Q. Do you know of any other hospitals in Northern Virginia that permit second trimester abortions?

A. Alexandria Hospital.

* * * * * * *

Q. Do you know of anyplace where a patient can obtain a second trimester abortion who is a minor and have the injection in the hospital without her parents [13] finding out about it?

A. In Virginia?

Q. Yes, sir.

A. No, sir.

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CROSS EXAMINATION

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Q. Doctor, you know what the word "terminate" means, don't you?

A. Yes, sir.

Q. Would you look at that 18.2--73 and tell me which word it is in there that you are having trouble with.

Statement sequence, do you know what it means to terminate a pregnancy?

A. Yes, sir.

Q. Do you know what it means to attempt to terminate a pregnancy?

A. Yes, sir.

Q. Do you know what it means to aid or assist in the termination of a pregnancy?

A. Uh-huh.

[14]Q. And you understand the language that you can do all those things provided it's performed in a hospital licensed by the State Department of Health.

Do you understand what that means?

A. Uh-huh.

* * * * * * * *

Q. You don't have any problem with any of those words, do you, doctor?

A. Not so far, except for the word "procedure," where it says, "provided such procedure is performed in a hospital."

[15]Q. Is the use of hypertonic sodium injected into the amniotic sack of a pregnant woman, is that a procedure to terminate her pregnancy?

A. Yes, sir.

* * * * * * *

Q. Let me ask you this, doctor. Do you know of any reason in medicine to put saline into the amniotic sack other than for the purpose of destroying the unborn child of that woman?

* * * * * * *

[16]Q. Do you know of any other reason medically to do that?

A. No, sir.

Q. That's what we do it for in medicine, isn't it?

A. That purpose?

Q. We're trying to terminate the pregnancy. Isn't that true?

A. Yes, sir.

Q. We are trying to destroy the fetus so that fetus will be expelled and the

child will not go full term. Isn't that true?

A. Yes, sir.

Q. Now, I just want to be sure of this. There is no other reason one would do that, is there?

A. Not that I am aware of.

Q. We don't use the saline solution for anything that you are aware of in internal medicine on a pregnant [17] woman other than to terminate her pregnancy?

A. That's right.

Q. It's not a treatment for the fetus, is it?

A. No.

Q. It doesn't improve the physical or mental health of the fetus. Isn't

that right?

Now, you said something about it would be pure speculation. I wonder, doctor, if you will take a look at that medical file on a 17 year old girl by the name of Patricia McDonald.

Then you will note down at the bottom of that file in the second portion there that Patricia McDonald came in and reported being five months pregnant.

Do you see that, doctor?

A. Yes, sir.

Q. And then right below that on 11/10/79, she was injected with saline. Do you read that?

A. Yes, sir.

Q. In a doctor's office, apparently. It's his gynecology chart.

A. (Nodding head.)

* * * * * * *

[18]Q. It would seem like an abortion was done on her, wouldn't it?

* * * * * * *

THE WITNESS: It does say a saline injection was done, yes, sir.

BY MR. HORAN:

Q. And then if she -- if that woman walked out into the outer office and paid $475 for that saline injection, it would seem like she paid for an abortion, would it not?

A. It says saline. I don't know what ROACS stands for, but same date.

Q. Doctor, if I were to tell you that that same 17 year old eventually delivered the child shown in Commonwealth's

Exhibit No. 2 and the child upon which a postmortem was done in Commonwealth's Exhibit No. 3, would you think it was speculation that the saline caused that?

A. I think that it would be probable, but nevertheless speculation.

[19]Q. Would it be reasonable to believe?

A. Reasonable, yes, sir.

Q. I mean, peanut butter wouldn't cause that, would it?

A. Not that I know.

Q. Saline would, wouldn't it?

A. It could.

Q. On that -- incidentally, if we add in that that fetus is 22 weeks, it's probably more probable that the saline was successful in this case. It's reasonable to believe that, isn't it?

A. Reasonable.

* * * * * * *

Q. So, doctor, do you want to take back your statement that it would be speculation as applied to this specific case?

[20]A. No, because I think that I couldn't say absolutely, unequivocally that I know this abortion was caused by that saline injection.

I will certainly accept your reasonable, even possible, but I couldn't say without speculation, if there is a tenth of a percent doubt about it.

Q. Are you telling this Court as a medical man that based on that evidence that you would be purely speculating to believe what caused that child to be

expelled from that uterus?

A. If speculation means there is some element of doubt, yes, sir.

Q. One chance in a million possibility?

A. I wouldn't know what the statistic lines would be.

* * * * * * *

[21]Q. Even we reasonable laymen, it's fair to reasonably believe the saline did that?

A. Maybe we are having trouble on words. I think reasonable, to me, doesn't mean that it's beyond speculation, that it could be something else.

Q. In other words, another way to say that, you are saying it is not beyond all possibility of doubt?

A. Yes, sir.

Q. Is that what you are saying?

A. Yes, sir.

Q. But it's probably true beyond a reasonable doubt?

MR. LUCAS: Objection, Your Honor. It calls for a legal conclusion.

THE COURT: Sustained.

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[22] MARCELLE WEISS,

* * * * * * *

DIRECT EXAMINATION

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Q. Are you a registered nurse?

A. Yes, I am.

* * * * * * *

[23]Q. How many years have you been practicing as a nurse?

A. About five years.

Q. Do you currently work for Doctor Simopoulos?

A. Yes, I do.

Q. About when did you start working for him?

A. September of '79.

Q. Do you work in the Falls Church Clinic?

A. Yes, I do.

Q. What is your position there?

A. I am his office nurse.

* * * * * * * *

Q. Let me call your attention to back in November. Do you recall a patient by the name of Patty McDonald [24] coming in?

A. Yes, I do.

Q. Was this the day she came in for a saline injection?

A. Yes.

Q. Was that any particular day that makes it stick in your recollection?

A. It was my son's eighth birthday.

Q. Did you at any time hand her any follow-up instructions?

A. Yes, I did.

Q. Could you tell us when that was?

A. When she walked into the room, she handed them to me and I handed them back to her.

Q. Did she try to give them --

A. Uh-huh.

Q. -- away to you.

Did she say anything at the time she did that?

A. She didn't say anything to me, but I told her she would need these.

* * * * * * *

[25]Q. Did you ever say anything to her one way or another about reading the instructions, postoperative [26] instructions?

A. Yes, I did.

Q. What did you say to her?

A. I asked her if she had read them.

Q. At what point in time was this?

A. After I had called the doctor. Well, before the procedure.

Q. Did she nod or anything? Did she give you any indication?

A. Yes, she did.

Q. What did she do?

A. She nodded her head yes.

[27] * * * * * * *

Q. What is the normal practice with providing patients with postoperative instructions? Who gives them to her?

A. The receptionist.

Q. Do you have any reason to believe there was any deviation from that in this case?

A. No.

Q. Did you go over any instruction sheets with Patty McDonald?

A. Yes, I did.

Q. In what point in time did you do that?

A. Before the doctor came in.

Q. Do you recall the doctor saying anything to her about going to the hospital?

A. Yes, I do.

Q. Could you tell us what you recall, to the best of your memory.

A. After the procedure was finished, she -- we sat her up and Doctor Simopoulos stated that she would go into labor in about 24 to 48 hours and that when the pains became strong and regular, to call him and he would tell her when to go to the hospital.

[28]Q. Do you recall that distinctly?

A. Yes, I do.

Q. When Patty McDonald left the treatment room, did she leave anything in there?

A. Yes, she did.

Q. Do you recall what she left?

A. She left the instructions.

Q. Did you take them back to her?

A. Yes, I did.

Q. Did she say anything to you when you did?

A. No.

Q. Was her boy friend present when you gave the instructions back to her?

A. Yes.

* * * * * * *

[29]Q. Did you ever at any time hear Doctor Simopoulos say it would be okay for her to abort in a motel?

A. No.

Q. Did you hear Patty McDonald say anything about going to a motel?

A. Yes, I did.

Q. What did she say?

A. She said that she was going to a

motel to wait it out. Doctor Simopoulos said, "well, don't go far," and gave her that before he gave her the instructions for her to go to the hospital.

Q. Did she say she was going to the motel to abort or just to stay there?

A. Just to stay there.

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[30] CROSS EXAMINATION

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[33]Q. Does the patient sign any form acknowledging the understanding of all these things?

A. For a first trimester abortion, yes.

Q. Isn't that the first trimester abortion sheet? (Handing item to witness.)

A. Yes.

Q. Every patient that comes in and does a first trimester fills out one of those forms?

A. Yes.

* * * * * * *

[34]Q. Now, you have the patients fill out all of those -- fill out that form and read it before they fill it out?

[35]A. Right.

Q. Isn't that true?

A. Yes.

Q. You don't do a similar thing with the second trimesters. Isn't that so?

A. That's true.

Q. All you do is hand the patient that post-injection sheet. Isn't that so?

A. I guess so. I am not involved with that.

Q. You are not involved with that?

A. Getting the consent on a second trimester, no.

* * * * * * *

[36]Q. Now, with a first trimester abortion, does the patient have that sheet in her hand when she first comes to see you?

A. Yes.

Q. She has got the sheet?

A. Uh-huh.

Q. She's filled it out and she's signed it?

A. Right.

Q. With a second trimester abortion, the patient comes in and just has the

sheet?

A. The post --

Q. It's not signed, is it?

A. (Shaking head.)

Q. On the first trimester sheet, you have a signature line, a date line, a time line and an address line?

A. Uh-huh.

Q. All of those things get filled out, don't they?

A. Yes.

Q. On the second trimester, all you have is that one sheet that doesn't even have a signature line on it? [37] Isn't that correct?

A. (Nodding head.)

Q. Isn't that true?

A. To my knowledge, yes.

Q. Is there any mistake about it? Is that one of the sheets that you are talking about, Commonwealth's Exhibit No. 6?

A. Yes.

Q. That's the one. There is no signature line on that?

A. No.

Q. No date line, no time line, no address line?

A. No.

Q. And it would be your testimony that on this particular day Patty McDonald walked in and had that sheet in her hand?

A. Yes.

Q. Under your procedure, that sheet would have been given to her by the receptionist?

A. Yes.

Q. The receptionist would have given it to her as she walked in the office that day?

A. Yes.

[38]Q. So, when she walks in, she has got that sheet in her hand?

A. Yes.

* * * * * * *

[39]Q. Was there any discussion that day as to how much it was going to cost her when she went into the hospital?

A. No.

* * * * * * *

Q. Was there any discussion of hospital costs?

A. Not in my presence.

Q. Does anybody tell the women what the hospital costs are going to be?

A. Not in my presence.

Q. Do they ever tell the women what the hospital costs are going to be?

A. I have nothing to do with that arrangement being made.

[40]Q. Have you ever -- have you personally ever told the women what the hospital costs are going to be?

A. I have no idea.

Q. So, with this 17 year old, you wouldn't even have talked to her about that?

A. No.

Q. And she indicated she was going to a motel?

A. Yes.

Q. That's what she said?

A. Yes.

* * * * * * *

[41]Q. Now, tell me the specific words that the doctor said to her when she said she was going to a motel.

A. He says, "Don't go far. When the pains start, wait until they get strong and close together and call me when they are strong and close together and I will tell you when to go to the hospital."

Q. Was the receptionist there?

A. Yes.

* * * * * * *

[43]Q. Did you check at all on Patty McDonald the following Tuesday?

A. The doctor mentioned something about her and I don't remember what he said.

Q. When you come in to work, did

you do any follow-ups to see if she had been to the hospital?

A. No.

Q. Do you normally check to see if they have been to the hospital?

A. No.

Q. The other saline abortions that were done in the month of November, did you check on any of those women to see if they went to the hospital?

A. No.

Q. Do you know whether any of them did?

A. No, I don't know.

Q. Well, now, if this 17 year old girl had been through that procedure and hadn't been to a hospital, would you worry about that at all?

A. Yes.

Q. But yet you didn't check on it on Tuesday morning?

A. No.

* * * * * * *

[45] REDIRECT EXAMINATION

BY MR. LUCAS:

Q. Is the medical follow-up your responsibility or somebody else's?

A. It is not my responsibility.

Q. Do you know whether or not the consent form is modified in any way for second trimester abortion patients?

A. No, I don't know that.

Q. The consent form is not your responsibility?

A. No.

* * * * * * *

[45] RECROSS EXAMINATION

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Q. Have you ever seen a second trimester consent form?

A. No.

Q. They don't have one, do they?

A. I don't know.

Q. Has any patient ever walked into your office with a second trimester consent form in their hand?

[46]A. No.

Q. What they have is the post-operative instructions?

A. Yes.

* * * * * * *

[48] DOCTOR CHRIS SIMOPOULOS,

* * * * * * *

DIRECT EXAMINATION

BY MR. LUCAS:

Q. Would you give us your full name for the record, please, sir.

A. Chris Simopoulos.

Q. Where do you reside?

A. We live in Fairfax Station, Virginia.

Q. Do you live there with your family?

A. Yes, sir.

Q. Would you give us briefly the size of your family, how many years you have been living there.

[49]A. We lived in Northern Virginia for the past nine years or so with my wife and the four children, our four boys.

Q. When were you first licensed to practice medicine and surgery in the

Commonwealth of Virginia?

A. 1969.

Q. When and from where did you receive your M.D. degree?

A. M.D., University of Athens Faculty of Medicine, 1966.

Q. Have you been Board certified by the American Board of Obstetrics and Gynecology also?

A. Yes, sir.

Q. When did you take those examinations and become certified?

A. The examination for the American Board of Obstetrics is administered in two parts. The written examination I took while I was training as a resident in New Jersey, New Jersey College of Medicine. The oral examination I took about two years later in Chicago.

Q. How many years have you been practicing now and for how many years did you have to study before you went into practice?

A. After high school, about 15 years training.

[50]Q. Since the time you started you became an M.D. That's been how many years from now, since now?

A. Since I became licensed and practiced medicine?

Q. Yes.

A. Since 1971.

Q. During the entire time that you have been practicing, have you engaged in the full range of obstetrics and gynecology?

A. Yes, sir.

Q. What hospitals did you do your further training in after you became an M.D.? What years?

A. I completed my residency training at Dalhousie University in Canada.

Q. Is that in Montreal?

A. Halifax.

Q. Halifax. Okay.

A. And the New Jersey College of Medicine in Newark, New Jersey.

Q. And you were on the OB/GYN residency staff in Newark?

A. Correct.

Q. You were within the OB/GYN department at that time?

[51]A. Yes, sir.

Q. What hospital staffs are you a member of at the present time?

A. Fairfax Hospital, Commonwealth, Potomac, Fauquier, Fairfax Surgical Center.

Q. What medical organizations and medical societies do you belong to in your practice?

A. I belong to the Prince William Medical Society, the Virginia Medical Society and the American Medical Association.

Q. During your years of practice, about how many deliveries have you done?

A. Approximately 100 per year.

Q. Have you provided prenatal and maternal care to patients as well?

A. Yes, sir.

Q. During your years of practice,

have you ever had a malpractice suit against you?

A. No, sir.

Q. Have you ever even had a speeding ticket?

A. No, sir.

Q. No criminal charges of any kind other than this case?

[52]A. None.

Q. Where did you grow up, incidentally, before you went to medical school?

A. I was raised in the mountains of Greek Macedonia in Greece.

Q. Did you descend from a line of doctors?

A. No, sir. My parents were illiterate peasants from the mountains of Greece.

Q. Have any of your family members come to the United States?

A. All of them did in the late 1950's as refugees.

Q. At the time you were doing your residency, did you have any experience with treating patients who came into the hospital who had suffered at the hands of non-medical abortions before?

A. Yes, sir. As a resident at the City, at the Newark City Hospital which was the University Hospital, I have been witness to all kinds of complications, the result of illegal, back alley, dirty interventions.

We treated them there. We had the most aggressive method of management which became a standard for the other

university and national hospitals, aggressive management, management of septic abortions, [53] complicated cases, yes.

Q. Were you involved in the management of thousands of such patients who had complications?

A. Yes, sir. We had the most cases in the country and it was directed by Doctor Breen who was our director.

As I said, we initiated, we studied and made the study which became a national standard in dealing with the septic problem complicated abortions.

* * * * * * *

Q. The patients that you treated for complications from non-medical abortions, how did those complications happen, in general?

A. Well, these complications resulted from illegal abortions by personnel or persons who were either neither [54] qualified nor doctors or did not follow the standard medical techniques and certainly were not done at our University Hospital. These were cases off the street and off anywhere.

Q. In your current practice, what general type of patients do you have? Would you describe your patient population as you doctor's put it.

A. Well, I don't discriminate against any patient. I see them coming to me from all walks of life; poor, wealthy, some of them, at least, middle class. I draw from a wide range of

socioeconomic strata.

Q. Do you treat Medicaid patients as private patients?

A. Yes, I do.

Q. Do you know of any other physicians in Northern Virginia that do that?

A. I don't think any other obstetrician in private practice treats Medicaid maternity patients in all of Northern Virginia.

Q. From what different sources do you receive referrals of patients around the State?

A. I get my patients from other patients, through direct patient referrals, patients from clinics, health [55] departments, Planned Parenthood, Birthright referrals, hospitals, all

sources.

Q. When you see a patient for prenatal and maternity care, do you receive more from that patient in terms of fees or do you receive more if they have a termination of the pregnancy?

A. Oh, by far, the maternity fee is greater than the abortion fee is.

Q. Would that be with the exception of Medicaid patients?

A. Correct.

Q. In your practice, do you also see patients who seek termination of pregnancy in the first and second trimester?

A. Yes, sir, I do.

Q. Has any patient ever aborted in your Falls Church Clinic?

A. No, sir.

Q. What is the title that you have given to the clinic and what is its address?

A. It's the American Women's Clinic.

Q. Have you made any attempts to get that clinic any special license as an outpatient hospital or anything?

[56]A. Yes, sir. I am in the process of applying and to get full licenseship for the facility.

* * * * * * *

Q. Prior to the time you were arrested, did you have any knowledge that the Commonwealth had an outpatient clinic licensing or an outpatient hospital licensing program?

A. No, sir, I did not.

Q. Prior to the time you were

arrested, did you have any awareness of any law in this State that might require that a saline injection be done within a hospital?

A. No, sir, I did not. The abortion had to take place at the hospital that I was aware of.

Q. Was it your understanding or what was your understanding as to whether an injection constituted an abortion?

A. It never crossed my mind. I didn't know about it.

[57]Q. Had you ever seen any medical definition of the saline injection as constituting an abortion?

A. No, I did not.

Q. Do you see any medical reason why instilling the saline solution needs

to be done in a hospital?

A. No, I do not, and certainly from my experience at the City Hospital, we used to do them in the emergency room, the patient's room and send them home. There was nothing that I had anything against it or reason to suspect that it would cause any problems.

This was a standard routine procedure at the City Hospital in Newark.

Q. What kind of equipment do you have within your Falls Church Clinic to deal with any kind of matters beyond ordinary office treatment?

A. Well, our clinic --

Q. Complications, for example.

A. Our clinic is fully equipped like any other operating room, hospital

operating room. We have complete anesthesia equipment. We have defibrillators. We have resuscitators. We have monitors, IV fluids, all kinds of drugs to be used in an emergency. It's fully equipped.

[58]Q. Do you have any kind of special certifications beyond OB/GYN for resuscitation?

A. Yes, sir, I do. I am certified by the American Heart Association to render emergency care under any conditions.

Q. Are you familiar with the treatment room at Fairfax Hospital where saline injections are done by some physicians who have testified?

A. Yes, I am. I am. I used them

myself many times.

Q. What equipment do you have that is not in that treatment room, if any?

A. The outpatient surgical unit at Fairfax -- I mean the place where they do the saline injections consists of one room, has one examination table, a light, ceiling light and some IV fluids.

It does not have any of the equipment which I mentioned earlier that I have at the clinic.

Q. You have heard some discussion in the testimony concerning the problem of injecting too much salt at the time an injection is done.

Could you describe to the Court if you have procedures to avoid that, what you do to avoid that.

A. I think here the miscalculation has been the way of doing the procedure. Complications have been reported in the past, but they did not use the technique which we presently use.

By this, I mean using the slow IV drip infusion. It's a test of safety, the best test of safety. It's administered over a period of about ten minutes and should there be any complications as a result of inadvertent injection of salt into the vascular system, into the circulation, we have signs and symptoms to warn us immediately, in which case we just stop the procedure and make another attempt, if needed.

Q. Would you then dilute the salt in the patients, wherever the salt was in

the patients, would you dilute that?

* * * * * * *

Q. What procedure would you utilize to deal with the salt that was in the patient's system?

A. If there was reason to suspect that salt was injected into the vascular tree, circulation, manifested by symptoms such as thirst, tingling on the patient's [60] toes or fingertips or thirst or headaches or anything like this, it would be a reasonable probability that the inadvertent, the accident had taken place.

All you do, first, you stop the procedure, and two, administer IV fluids, salt -- excuse me, I mean dextrose, five percent dextrose in water, just a plain IV

fluid to neutralize, to dilute the salt and in a sense, neutralize it.

Q. When the salt is injected in the uterus, does it get diluted in the patient's system at all?

A. No, it does not. It is confined to the amniotic sack which is inside the womb, the patient's uterus.

Q. Initially in the procedure?

A. And eventually, of course, it may, after awhile, of course, it would have to be neutralized and some of it would be absorbed by the patient's blood stream and eliminated by the kidneys.

Q. What procedure would you utilize to avoid the problem of bleeding when the patient delivered the fetus, both precautions and procedures.

A. Well, I do advise my patient to return to the hospital for the delivery, the abortion itself, consisting of [61] the fetus and placenta. At the hospital, of course, if there is any bleeding, we have plenty of time to type them and cross-match them and wait and see and try to remove -- remove the products of conception and administer fluids before we consider the administration of transfusion.

Q. In your experience, does any kind of bleeding take place shortly after the saline solution is instilled?

A. Never.

Q. Is that a complication that is of any concern in the literature at all?

A. No.

Q. Is it almost invariably associated

with the delivery or at any other stage?

A. Correct.

Q. Let me bring your attention to November of this past year. Do you recall a patient by the name of Patty McDonald coming in?

A. Yes, I do.

Q. Would you describe to the Court the impressions that you had of the patient's condition when you first talked with her, where you were talking with her and what day that was.

A. Well, as a matter of fact, I tried to forget the [62] date, but I know it was on the 8th of November. She came into my office with her boy friend, seeking a second trimester abortion.

Of course, I first saw her in the

examination room, the doctor's examination room. She appeared to be very apprehensive, very depressed, very fearful at that time. It's not unusual.

I did perform a thorough physical examination on her and determined her pregnancy to be about 18 to 20 weeks, five months pregnant.

Q. Did your impressions include any of your conclusions about the situation with her family? Was that of any part of your conversation?

A. Yes, of course. She told me that she was very, very, very terrified of her parents. She did not want her parents to know anything about it.

Q. Is that uncommon with minors?

A. I would think that when it comes to second trimester patients, this may not

have been an unusual reaction, but she was a little more than apprehensive or depressed.

She was so terrified that it left a hard to erase impression on me at that time.

[63]Q. Did she cry at all?

A. She cried on several times.

Q. What points in your conversation with her did she cry?

A. Well, I mentioned after the examination that she was five months pregnant. As I do with all of my patients, this stage of pregnancy, I explained to her that she really had two options.

One is to carry the pregnancy to term in which case I would have been glad to take care of her as I have done for

other patients in my practice.

Q. How did she react to that?

A. She started crying and did not even want to consider it. Then I asked her if she had discussed this matter with any member of her family. She said certainly not and then she started crying again.

I tried to explain to her that under those circumstances it sometimes -- it's very beneficial for the patient to talk this matter over with her parents and I told her that you would be surprised. Sometimes parents can be more understanding than you are willing to give them credit for.

Again, she would not listen to this sort of thing [64] at all and

started crying. Then I took up the other second option that she had.

I said if all goes well, if you decide against pregnancy, if you decide not to carry the pregnancy to term, then, of course, you have the other option of terminating the pregnancy.

At that other point she became somewhat calm and I thought regained her composure and then I went ahead and explained to her all the -- what the termination of pregnancy at this stage implied.

* * * * * * *

Q. Did you describe in any way to her what the delivery process would be?

A. I certainly drew the distinction between a first trimester abortion and

the second trimester abortion. I explained to her that -- the procedure, first, what she could have, how we proposed to terminate the pregnancy.

This entailed, I explained, injecting salt and then sooner or later, if all goes well, you would [65] go into labor, at which time both the fetus and placenta would be expelled.

Q. Did she ask you any questions about what you meant by "fetus" and "placenta?"

A. I told her that there was the little fetus. I must have mentioned. I don't recall exactly the exact words.

Q. Just what is your usual description, if any, of a fetus to a patient. Do you go beyond calling it a fetus?

A. No. I say it's a small -- it's like a small baby, very early, premature, and the placenta, the afterbirth. I did explain that.

Q. Did she ask you any questions about further describing the fetus?

A. Well, she did not ask me questions about fetus or placenta, but I was under the distinct impression that she understood and she understood all the risks and complications that do arise as a result of the procedure.

Q. Do you generally, yourself, provide the patient with the explanation of risk, alternatives, complications verbally?

[66]A. Yes, I do, most certainly do.

Q. Who is in charge of consent forms

in your clinic?

A. My administrator, manager of the office.

Q. Were you satisfied that she sufficiently understood the procedure?

A. I most certainly was. I still told her -- I told her that I want you to go home, try again to talk with somebody that is responsible, your parents or whomever, and then if you decide, I want you to think about it before coming back for the procedure.

I didn't expect her finally to come back and she did within two days which was the 10th of November.

Q. Did you know whether she had any limited funds or not?

A. She told me that. She did not

have any money.

Q. Did you have any discussion with her about whether she could be admitted as an inpatient at the hospital?

A. Oh, yes, I told her. The instructions that I pointed out to her that the manager of the office would hand her the post-injection information sheet which included all that she needed to know in coping with this sort of problem. [67] In some sort of way I explained to her that I wanted her to come back to the hospital, Fairfax Hospital, which is the only hospital that I use for this purpose and that should she have any problems and questions, my numbers were on the sheet. There were two numbers, one metro number and the other one Prince William

number, local for her.

Then, that is, as it is accustomed in the office, I have the administrator go over with the patient over the information sheet that she was handed out.

Q. Does the Fairfax Hospital require parental consent for second trimester minors?

A. Yes, it does.

Q. Can you avoid that in any way if the patient is delivering in the emergency room?

A. Yes, you can, I suppose. It depends on at what stage of the abortion they come in. If they come in too early, before the labor really starts, it would be hard to keep her in the emergency room

for several hours.

But if she were to come when the pains were strong and regular and effective, then she could very well be dealt with, treated in the emergency room and sent home.

Q. Where would they put her in the emergency room until she aborted?

A. There are several side rooms there.

Q. Is that a busy emergency room?

A. The busiest in the area, yes.

Q. Do you think a patient would be able to avoid telling who her parents were in an emergency room for about what period of time?

A. That's the administrative part of it, but I know that the business

girls there at the hospital and the administration wants to get a hold of the patient as soon as they come in, actually, in some cases, primarily because they do want to get payment for it, to know who is the financially responsible party.

But they would not have turned the patient away on financial grounds since this is not (sic) longer considered an elective procedure. It's a medical procedure and the patient has to receive care, financial consideration notwithstanding.

Q. In your practice with patients who seek to terminate their pregnancies, do you usually urge them [69] to talk to their parents or not?

A. Yes, I do, most certainly do.

Q. What if they don't want to get parental consent? Do you treat the patients anyhow?

A. I do.

Q. Do you consider it their right?

A. Yes, sir, I do. I think it's their right.

Q. Do you consider it good medical practice?

A. I think so. We don't want to be judgmental about it. Our purpose is to render care, medical care where care is needed and not to deal with any other stipulations.

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[70]Q. Do you have any basis to be concerned about particular problems if you

turn a patient away?

A. Well, these patients are very desperate. Patients seeking second trimester abortions are, as a rule, very young, very poor, uneducated, ignorant and very desperate. They want to get an abortion no matter what.

I have seen cases where self-destructive or self-induced abortion took place with complications. I have seen patients who committed suicide because they could not get an abortion and they did not want their parents or relatives to know about it, and I strongly suspect that everytime there is a suicide of a pregnant young lady as being the cause of it.

Q. Have you ever seen patients who

were as young as 12 or 13 forced through pregnancy?

A. Yes, sir, I did. As a matter of fact, I had a patient once referred to me by another doctor.

* * * * * * *

[71]Q. Turning back to Patty McDonald and her situation, do you recall giving her any personal instructions when she was leaving the treatment room?

A. Well, in essence, I reiterated to her in the -- while I was doing the procedure which took place over a ten minute period, the do's and don'ts throughout in the operating room.

When she left, I told her to follow the instructions to the letter, the written instructions to the letter.

She told me that she was not going home because of the family situation.

She mentioned upon leaving the operating room that she was going with her boy friend and stay at a motel. I had no idea what the motel was, but I did make it clear to her that do not go very far. I want you to be in close proximity to my office and the hospital [72] and do call me when you have labor pains and I will tell you exactly when and what to do.

In fact, I went one step further. I gave her a prescription for percodan and told her to take these drugs, one every so many hours, to sustain you, to take care of the pain in the early stages.

Then when the pains get too much,

come back to the hospital and I will see you. I will meet you. I will treat you at the hospital, Fairfax Hospital in this case.

Q. After she told you about her problem with her parents, did you tell her there was a possibility that she could abort at home?

A. I mentioned this possibility as a -- in a general -- when I gave her my general instructions and explained the risks and complications. I told her that sometimes the delivery can be very quick and that this could have happened anywhere, but then she ought to let me know regardless.

I also mentioned to her that if nothing happened within 48 hours, do let

me know.

Q. Do some patients not abort?

A. Yes, sir, they do not. The saline injection is not 100 percent guaranteed method. The most you can [73] expect is 90 percent efficiency, effectiveness. The other 10 percent do not work and I have had patients that I personally, on whom I personally had to re-administer the salt injection to cause the termination of the unwanted pregnancy.

Also, I did a patient at Fairfax Hospital following failure of saline injection and administered drugs, intravenous pitocin as well as suppositories, prostaglaudin suppositories, to cause the termination of this pregnancy.

Q. Can you tell by looking at a

picture of a fetus such as those that have been made exhibits whether or not the saline in fact caused the fetus to be expelled?

A. No, I cannot.

Q. Do you consider those pictures as a valid scientific basis for any kind of conclusion?

A. None whatsoever.

Q. Have you ever -- do you know where or did you at that time know where the Howard Johnson Motel was?

A. I still don't. I don't know where it is.

Q. Did the patient ever call you?

A. No, sir, she did not.

[74]Q. Do you have a 24 hour answering service?

A. Yes, I do.

Q. You have seen the follow-up sheets. From the numbers on the follow-up sheets, could you be reached at any time, day or night?

A. Anytime, 24 hours a day, yes.

Q. Do you have any record of her calling you at all?

A. No.

* * * * * * * *

Q. Just for our benefit, since we are attorneys [75] and semi-lay people, what is "amniocentesis?"

A. Amniocentesis with instillation of hypertonic saline, as we use the term in medicine, is the withdrawal of the amniotic fluid from the amniotic sack and injecting high strength concentration,

20 percent concentration of sodium chloride into the same space.

Q. Is amniocentesis an office medical procedure or hospital medical procedure?

A. Amniocentesis is done very frequently by many doctors in their offices for diagnostic purposes such as studies, chromosomal studies, genetics and so forth.

* * * * * * *

Q. Where did you expect this patient to abort the fetus?

A. At the hospital.

Q. At which hospital?

A. Fairfax Hospital.

Q. Do you need to make any kind of advance arrangements for the emergency room there?

[76]A. No, not the emergency room, but I call them when the patient is ready to go. Since there is a great deal of uncertainty as to when she might go into labor, sometimes. The only time when I do this is if the patient can provide the financial means and the patient, the hospital has to know ahead of time who is coming and who is going, and by giving the business office this information, they call them up and say, you know, how are you going to pay for it when you come in.

But other times I just wait until they go into labor, if they do go into labor, and then call the hospital and say I am sending in patient such and such. She will be there at such and such a time. Call me when she arrives, et cetera, and

I do sneak a few patients in without --

Q. Parental consent?

A. -- without financial means.

Q. How do you do that?

A. I just don't call them. I surprise them. I surprise the hospital and then they get on my back and say why did you bring her here when you know that she doesn't have insurance, so forth and so on.

* * * * * * *

[77]Q. Have you injected any patients with saline since Patty McDonald?

A. Yes, sir. I did at the hospital.

Q. In your clinic, I mean.

A. No.

Q. Do you consider the law clear or unclear about this?

A. I am not yet clear. I guess since I have been prosecuted, I have no reason to even consider the contrary and keep doing them. I am not very clear on the law, still.

Q. You keep doing them in the hospital now?

A. That's right.

Q. What if a patient left the hospital that you injected in the hospital, do you worry about being prosecuted in a case like that?

A. No.

* * * * * * *

[80] CROSS EXAMINATION

* * * * * * *

Q. Doctor, why did you inject the saline into Patty McDonald?

A. The patient came to see me because she didn't want her pregnancy continued. She wanted to have her unwanted pregnancy terminated and I injected the salt in an effort to have that pregnancy terminated.

Q. In other words, you were doing an abortion?

A. I was doing a salt injection, yes.

Q. And that aborts her?

A. Not necessarily.

Q. Was it your intent at that time that the fetus should die?

A. I was concerned with my patient's health. I was not concerned at that point about the fetus.

Q. The saline kills the fetus, though, does it not?

A. Sometimes.

* * * * * * *

[81]Q. Did you think it was going to kill the unborn child?

A. There was a possibility of it, yes.

Q. Well, that's what you wanted to happen, wasn't it?

A. That's what the patient wanted to happen.

[82]Q. And you also wanted it to happen?

A. I wanted to do what was best for her.

Q. So, therefore, she thought what was best for her and you thought what was best for her was to kill that unborn child?

A. To terminate the unwanted pregnancy, correct, sir.

* * * * * * *

Q. Doctor, you knew that if the

procedure worked, the child would be destroyed?

A. If the procedure worked, the fetus could have been destroyed, correct.

[83]Q. It would have been if the procedure worked?

A. If successful, correct.

Q. Isn't that so?

A. If the procedure had succeeded it.

Q. You didn't intend that the procedure not succeed, did you?

A. The procedure is not 100 percent safe and effective.

Q. I am talking about what your intent was. You aren't going to take $500 from this woman on the hope that it wouldn't work, would you?

A. I don't understand the question

of finances here.

Q. Well, you understood that if you were successful, the unborn child would die?

A. If I -- if the procedure had succeeded, then the pregnancy would have been terminated, correct.

Q. And the unborn child would die?

A. I was not dealing with any child at that point.

Q. But that would be the effect of your procedure being successful?

A. Well, the effect of my procedure, had it been successful, would be to terminate an unwanted pregnancy at five months gestation --

[84]Q. And thereby the child would die?

A. -- in the expulsion of the fetus and the placenta.

Q. And thereby the child would die?

* * * * * * *

Q. Do you understand my question? If the procedure you used was successful, the child would die?

A. Well, I don't agree, certainly, with the terminology of it and I have a right to do so, since I don't understand the terminology.

Q. Well, she had within her, I think you used the term when you were talking to her, "the baby."

A. The fetus.

[85]Q. I think on direct examination, we can have the Reporter read back, you said baby.

A. Only to explain the patient what the fetus meant; not as part of my own vocabulary which I would use in speaking to somebody at medical levels.

Q. We aren't on the medical level now. You used it in talking to her, to Patty McDonald?

A. To make it very clear that the fetus, since she did not understand the term fetus, I had to use a similar term to make it clear to her and therefore to know what we were talking about, yes.

Q. I don't want to quibble with you, doctor. Fetus is a baby.

A. I don't agree, but I think you are entitled to your definition of it as I am to mine.

* * * * * * *

[88]Q. Did you intend that the fetus die as a result of your procedure?

A. Yes. The intention was to terminate the unwanted pregnancy, period.

Q. The intent was that the fetus die?

A. The pregnancy terminated. The fetus was not my patient. My patient was Ms. McDonald.

Q. I understand, doctor. As a result of your procedure, it never could have been your patient. Is that correct?

A. Could have been if she had chosen to come to me for maternity care, yes.

Q. But once you exercised the procedure, there was no chance that fetus was ever going to be your patient?

A. If the procedure had succeeded.

Q. Did you intend that it succeed?

A. Yes, I did.

* * * * * * *

[90]Q. How long does it take to do a first trimester abortion?

[91]A. It depends on how far she is. It can take anywhere from 10 minutes to 30 minutes.

Q. How about a second trimester abortion? How long does that take?

A. Second trimester is quite a different procedure. First we do the salt injection.

Q. How long does that take?

A. That takes no less than the surgical procedure, the surgical intervention itself, takes ten minutes or more or thereabouts.

When the patient has to be prepped

and ready for the procedure prior to this time, so it takes on the average of 30 minutes or so from when she walks into the operating room for 30 minutes and leaves the operating room after that.

Q. What percentage of your second trimester abortions actually go to a hospital?

A. Percentage, I have not sat down to --

Q. I just want an approximation. Half of them?

A. I have to -- at least that much.

Q. At least half?

A. But I have a few patients that I injected at the hospital, Fairfax, make arrangements for them to [92] return, never returned because they aborted

quickly at home, uneventfully and didn't bother to call me.

I found out on subsequent inquiry what has happened to them.

Q. Is the fee $500 whether they go to the hospital or not?

A. No, sir.

Q. Pardon?

A. The fee is a down payment which includes the initial -- the salt injection. It includes the delivery, includes the postop care, includes any hospital visitations and office visitations as well.

Q. And that money is normally paid in advance?

A. That's right.

Q. If they don't go to the hospital,

do you give part of the money back?

A. Yes, I do, but this has never occurred.

Q. Have you given any of the money back to Patty McDonald?

A. No, I have not. I have no way of locating the patient for that purpose and I discussed this with my advisors.

Q. You have her address in the file, don't you?

[93] MR. LUCAS: Your Honor, let me object. I am sure that the first person who would accuse us with tampering with the witness if we ever talked to her and offered to give the money back would be Mr. Horan.

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[94]Q. Did you make any notes about her being extremely upset?

A. No, I didn't, but again, this was part of the whole situation. In other words, the procedure was done because the patient, under the circumstances, was very depressed and wanted it and so forth and so on.

Q. Did you make a note in there --

A. No, I didn't.

Q. -- that she was depressed?

A. I didn't have to make a note to that effect [95] because I knew that patient and the only one who would have access to these charts would be me, nobody else.

Q. But you made no note that she was depressed?

A. No.

Q. You made no notes about the fact that she didn't want her parents to know?

A. I didn't, but the patient admitted it both at the preliminary hearing and the Court and this agrees with my knowledge.

Q. Doctor, you didn't prepare that file for preliminary hearing. That file was your medical file, wasn't it?

A. That's correct.

Q. And that file wasn't something you would need for preliminary hearing. That was for your understanding of your patient, wasn't it?

A. Yes, but I knew the patient, so I chose to write just only the pertinent information that I had to deal with

subsequently.

Q. Now, tell us what you wrote about that patient on November 8th.

A. I wrote that she was pregnant, five months, and put down scheduled for saline injection.

[96]Q. Scheduled for saline injection?

A. Right.

Q. So, as of the moment she walked out of your office, you knew she was going to be injected with saline?

A. No, I didn't. I had a conversation with the patient. I explained to her the risks. I explained to her what she should do. I talked to her and mentioned that she should talk to her parents and then if she decided to have the pregnancy terminated, then she would

call my office and then she would be scheduled for such procedure.

I have no dates here to indicate that I would have done it two days later or two weeks later or two years later, you know, anything. So, it's simply an incomplete chart, left open the date, left open the time of the proposed surgical procedure because the patient had to decide it.

Q. The patient what?

A. Had to decide that particular question.

Q. When did you first become aware of the fact that this patient had decided to have the saline injection?

A. Well, I knew that there was a patient who had been scheduled to see me

on that particular date, the 8th, [97] for saline abortion, saline injection, from the secretary. I know I call her ahead of time and say what do you have for today, how is the workload.

I time myself, the scheduling and so forth, so I knew there was such a patient to come on that particular day to discuss with me, explore the possibility of a saline abortion.

Then I saw her, examined her, found her to be as far along as I indicated in the record and explained to her in every detail what she should know about the procedure and left it up to her, take her time, calm down, because what I don't ever do is to perform any surgical procedure, any procedure, period, under duress, while

the patient is extremely nervous, apprehensive or the possibility exists of her misunderstanding me and so forth and so on.

I think because of this consideration, because of this caution I take, I haven't had a malpractice case forever.

Q. Doctor, do you understand my question?

A. Yes, I do.

Q. My question is when did you first know she was going to have the saline done?

[98]A. When she came two days later, Saturday.

Q. On Saturday?

A. (Nodding head.)

Q. Were you surprised she was there?

A. No.

Q. You weren't surprised at all?

A. No, I was not.

Q. When did your receptionist tell you she had scheduled her for saline?

A. She tells me every day, prior to the day of the operation or whatever.

Q. So, do you know when the agreement was made between she and your receptionist for the saline?

A. No, I don't, but I know, I usually, as I mentioned, ask my receptionist to know what sort of patients and how many we might be having the next day and she tells me we have so many general gynecology patients, so many patients for maternity, so many patients for abortions, so many patients for consultation, so many patients for infertility, so many patients

for pap smears and birth control pills and so forth.

I have a pretty good idea as to how many patients I would have.

[99]Q. Do you know when --

A. The day before.

Q. -- Patty McDonald did? The day before. That would have been the 9th?

A. Late afternoon, Friday.

Q. You saw her on the 8th. On Friday, she calls in and sets it up for the 10th?

A. Well --

Q. You saw her on Thursday, the 8th. Friday she calls in. You do it Saturday?

A. I don't know when she called.

Q. Would it have been before Saturday?

A. Yes, sir. I would think so.

Q. So, that would have made it Friday,

wouldn't it?

A. Again, I don't know when. She might have called the same Thursday afternoon for all I know or Friday morning or Friday afternoon or left a message with my answering service. I don't know.

Q. As a matter of fact, she could have told the receptionist on the way out?

A. Could have, but I don't inquire into it.

* * * * * * *

[100]Q. Doctor, you indicated that, I think your quote was, "this girl didn't have any money."

A. (Nodding head.)

Q. Now, when you were talking to her on the afternoon of the 8th --

A. Morning of the 8th.

Q. -- morning of the 8th, you already told her it was going to cost 500 bucks?

A. I told her that the procedure was going to cover -- how much. She knew already how much we charged because the manager had explained to her what we usually charge, separate fees. So, I just wanted to be sure that she understood and what we had to do, what it would entail.

I didn't want to give the impression I am making 500 bucks for just patting the patient on the shoulder and so forth and so on. She knew all these things, but I had to make sure that she better understood it.

Q. Did you also explain to her how much Fairfax [101] Hospital was going to cost her?

A. Yes. The manager does, did.

Q. Well --

A. The manager does on the phone. We have no idea. When a patient calls for a second trimester abortion, we tell them exactly what the hospital cost is, exactly how much our cost would be and when we see the patient, we know where we stand.

We know if the patient would qualify to have the procedure done at the hospital and what, et cetera, et cetera.

Q. So, when you were talking to her on Thursday, the 8th, she knows it's going to cost her $500 for you plus how much money for Fairfax Hospital?

A. No. I did not mention Fairfax Hospital to her at all because I knew that she could not qualify for it because of

the parental consent consideration. So, I did not raise the question of Fairfax at all with her.

The secretary, the receptionist might have, but I did not because I knew the law, the policy in Fairfax.

Q. So, as far as you know at that time she wouldn't be going to a hospital?

A. I knew for sure that she couldn't because she told [102] me right in the beginning she didn't want her parents to know and I knew that the Fairfax Hospital required parental consent. Therefore, it was out of the question.

Q. So, that means as of the time you injected her on Saturday morning, you knew she wouldn't be going to a hospital?

A. I didn't say that. I said that to

have the salt injection she couldn't have gone to the hospital. But she could have come back later to abort at the hospital because then she would have been treated as a medical emergency, a medical problem and not as an elective procedure, elective abortion procedure.

Q. Did you tell her how much that was going to cost?

A. The secretary, originally.

Q. Did you tell her how much it was going to cost?

A. No, I didn't.

Q. You have this 17 year old girl in front of you who doesn't have any money and you didn't tell her what Fairfax Hospital was going to cost her?

A. I didn't.

Q. You didn't?

A. Because I left it up to my business manager to [103] explain all these things to them.

I try to not get involved with the financial aspect of my patients at all, if I can help it.

Q. You never get involved?

A. I don't want to, but sometimes I have to, because it creates problems of misunderstanding.

Q. Let me ask you this, doctor. When -- when did you call this girl after you had done the saline?

A. I didn't. The thing of it is, our procedure, office procedure is the following. We do the procedure wherever, Fairfax, and we tell them to wait. If nothing

happens within two days, to call our office, and I do so because we have to reschedule them for another saline injection. We run into timetables and operating room schedules at Fairfax where we do them only in the first three days of the week.

Q. Did you hear my question, doctor? When did you call her?

A. I didn't.

Q. You never did?

A. I didn't call her.

Q. Forty-eight hours had passed as of noon on Monday?

A. True, and then I had surgery in the morning. [104] I saw patients in the afternoon at the office and when I returned to the office, I got a call from the Medical Examiner's, Mr. Dooley, rather,

who briefed me on the case. So, I have no reason at all to call her at that point.

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[106] Certainly it was not my responsibility to call. I had no intention of calling her home and discussing this matter with her mother or father or anything. I don't do this, except with the patient's full authorization and the patient's understanding.

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[109] MR. HORAN: I think it's proper inquiry as to whether or not it ever happens.

THE COURT: Objection overruled.

THE DEFENDANT: I don't quite understand. You mean maternity or abortion?

BY MR. HORAN:

Q. Abortion.

A. I don't recall. I have to again review my books.

Q. Have you ever had one?

A. Yes, of course. Single girls, under the age of 18, minors, between the Fairfax and Potomac, yes.

Q. Is there some reason why this girl wasn't going to go to Potomac?

A. She could have gone if she had -- she lives in Prince William. If she had chosen to go to Potomac Hospital because of the proximity, I think she wouldn't have because her parents lived there. But if she had, I was in a position to cope with it. I would have taken care of it, regardless.

Q. The girl is from Woodbridge?

A. That's correct.

Q. Potomac is right outside of Woodbridge?

[110] A. Yes, but Potomac is one of the two Prince William Hospitals and simply does not have the manpower, the trained personnel or the desire to take care of these patients. So, they object to it.

It creates administrative problems and I discourage them from going to Potomac for that reason.

Q. Did you discuss with her at all going to Potomac as opposed to going to Fairfax?

A. I had mentioned if there is any medical problem that could not wait for her to come to Fairfax Hospital, then she

could have gone to the emergency room at Potomac and under those circumstances, as I had one patient or two at Potomac.

Q. When did that discussion take place?

A. Well, this is part of the general discussion and both the consultation, at the time of consultation which was the first day. I gave her all the details, all the risks, everything on the first day, consultation day, and exactly whether I went over the very same details the next day, I just don't keep account of that.

Q. You don't remember that on Saturday? You didn't go through that on Saturday or did you?

A. I told her to follow the instructions on [111] Saturday, the written post-

injection instructions Saturday, and to come -- to follow the instructions and if she has any problems, to call.

Q. Had she followed the instructions that you gave her on Saturday, which hospital would she go to?

A. Fairfax.

Q. She would go to Fairfax?

A. (Nodding head.)

Q. When did you tell her that?

A. It was in the instructions.

Q. Do the instructions say Fairfax Hospital?

A. That's right. Let me see.

Q. Show me where that is.

A. Well, I must have remembered the revised form. I don't see it here.

Q. It's not in there, doctor, is it?

A. Well, I must have in mind the revised form because I made it clear. We print these forms and reprint them to satisfy -- I am surprised. I don't see it here.

Q. It's not in there, doctor, is it?

A. Well, that's the only hospital that we refer the patients. If it's not there, it's in the other [112] form we have at the office.

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[113] A. There is no way to do it at Potomac. There is no way. They do not want -- they don't like -- they are very hostile to these patients.

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[115] Q. When she left your office on the 8th, it was fairly obvious she was

going to have the saline abortion?

A. No, sir. She was calm, composed, relieved, but then to exercise the choice, the option of abortion, was entirely up to her and I had no business in influencing her one way or the other.

[116] Q. Didn't you indicate this morning that she was very calmed down once you explained this procedure you had?

A. Yes.

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[118] REDIRECT EXAMINATION

BY MR. LUCAS:

Q. Doctor Simopoulos, did you do what the patient requested you to do to help her?

A. Yes, sir.

Q. Did you do what you thought was

medically proper in treating her?

A. Yes, sir, I think so.

Q. Did you do anything that you thought was illegal?

A. No, sir.

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[119] CAROL SHAPIRO,

* * * * * * *

DIRECT EXAMINATION

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Q. Do you know Doctor Chris Simopoulos?

A. Yes.

Q. About how long have you known him?

A. I have known him since I have been in practice in the Woodbridge area in 1972.

Q. Is he one of your neighbors?

A. Yes. He lives in our development.

Q. Are you an officer in the medical society that he belongs to?

A. Yes. I am the President of the Prince William County Medical Society.

Q. Do you know of other people in the community also [120] that know him?

A. Yes.

Q. Have you had occasion to speak to other people in the community concerning the Defendant?

A. Yes.

Q. Do you know of his reputation in the community?

A. Yes.

Q. Would you tell us what his reputation is in the community.

A. He has a good reputation as a good

obstetrician-gynecologist.

Q. Does he have a reputation as a good truthful man?

A. Yes.

Q. As a good family man?

A. He is known as a good neighbor and a good father and a good husband in our community.

Q. Doctor Shapiro, you also indicated to me that you had some knowledge of the subject matter of informed consent and the patients recalling explanations and things. Is that correct?

A. Yes.

* * * * * * *

[123] Q. Have there been any more studies that you know of concerning patients blocking out information about complica-

tions?

A. There have been several studies. The one I was referring to when I spoke to you was a very recent study that was done on surgical patients and it was done by a surgeon.

Q. And is it the type of study on which physicians would rely as an authoritative and informative study on the subject matter?

A. Yes, I think so.

Q. Did it cover information about patients recalling the discussions of complications?

A. Yes. Can I say something about what --

Q. You certainly may explain the

study.

A. The general scope of the study, it was done on 20 patients who had preoperative interviews with their surgeons prior to the surgery, immediately prior to the [124] surgery, upon admission to the hospital and with the patient's approval.

* * * * * * *

Q. Can you tell us what types of surgery were involved and what types of patients were involved.

A. It was general surgery and these were preoperative patients between the ages of 30 and 45, who were admitted to the hospital and interviewed by their surgeons.

By a preagreed consent, the conversations were taped and then three to four months after the surgery, the patients were reinterviewed and what they essentially asked them were questions regarding the content of this [125] preoperative discussion.

What it showed was that only 29 percent of these patients had any general recall as to what had been discussed with them concerning what the operation was about, what the potential complications were and what any alternatives were, if there had been any.

The majority of them actually denied hearing anything at all about com-

plications.

* * * * * * *

[126] FATHER THEODORE CHELPON,

* * * * * * *

DIRECT EXAMINATION

* * * * * * *

Q. What is your profession, sir?

A. I am a priest. I am the pastor of Saint Catherine's Greek Orthodox Church.

Q. Do you know Chris Simopoulos?

A. Yes, I do.

Q. Approximately how many years have you known him?

[127] A. For approximately five years.

Q. Could you tell us generally under what circumstances you have known him.

A. Doctor Simopoulos is a member of my parish, a very active member of my

parish. I have known him through his worship. I have known him socially in his home and in many functions of the parish. I know him very well.

Q. Do you know other people in the community who also know him?

A. Yes, sir. There are several people in our community that know about him. I would say at least 100 people in the parish know him.

Q. Did you volunteer to be a character witness on his behalf?

A. Yes, I have.

Q. What would you say his reputation is in the community?

A. He has an excellent reputation. He is known to be a truthful man and a faithful man and a man devoted to his

family, a man devoted to his duty to his fellow man as they need his services.

Q. Have you ever heard any adverse remarks reflecting [128] upon his reputation?

A. Never a word.

* * * * * * *

MR. LUCAS: Your Honor, before we close, I suppose we have a few wrap-up matters to take care of.

We have no further witnesses.

We certainly would like to renew all the previous motions that we have made, and if there are any exhibits we haven't moved into evidence, to move each and every one of them into evidence for the purpose of the trial on the merits, including the exhibits in the hearings on the motions and the testimony in the hear-

ings on the motions, to the extent that they are relevant.

* * * * * * *

[129] MR. HORAN: I don't think I have any objection to any of them during the trial.

THE COURT: Well, I think he is moving to introduce those that were marked as exhibits during the pretrial.

MR. LUCAS: For example, the Fairfax Hospital policy was initially introduced at the motions hearings and we think it should be an exhibit also to the trial because it was referred to and testified to.

* * * * * * *

[134] MR. LUCAS: I think that's very true, Your Honor.

We are prepared to rest and to be ready for closing arguments in five or ten minutes, but we certainly renew all of our motions, including our motion to strike.

THE COURT: I will deny all your motions again for the same reasons previously stated.

* * * * * * *

CLOSING ARGUMENT ON BEHALF OF THE COMMONWEALTH

MR. HORAN: Your Honor please, I will be brief. In spite of three days on carrying on in this case, it's essentially a rather simple factual matter.

[135] The issue is whether or not under the law this Defendant used some means to destroy the unborn child of Patricia McDonald and thereby terminate the life of

that child.

I would submit, Your Honor, on any conceivable evaluation of the evidence, that's exactly what he did. He injected her with a saline solution that if successful, terminates the life of that unborn child. The evidence is clear and overwhelming the life of that child was terminated.

Going into his own medical records, there is an indication that's what he wanted to do and that's what he accomplished.

If you are in 18.2--71, you then have a completed crime and the issues are can there be any doubt, reasonable or otherwise, that he set the whole thing in motion. The answer is no. There is no doubt.

Number two, did the means that he used destroy the life of that child. I submit there is no doubt, reasonable or otherwise, that's exactly what he did.

That being complete, he has violated 18.2--71, unless he gets one of the escape clauses that exists in 18.3--73. If he has got some out in that section, [136] then he is not guilty of this offense.

We get to 18.2--73, the law allows him, as a physician, which he is, to terminate or attempt to terminate the pregnancy during the second trimester, if he does it in a hospital that has been licensed by the State Department of Health or under the control of the State Board of Mental Health and Retardation.

Your Honor please, on the evidence, he

terminated, whichever term you want to use, terminate or attempt to terminate, either one, he did that in a place other than a hospital licensed by the Department of Health of Virginia.

I submit to Your Honor that there is no doubt, reasonable or otherwise, that's exactly what he did. He terminated this pregnancy outside of a hospital.

All of the window dressing about what he thought the law meant or thought the law should be or whether he agrees with it or not is quite beside the point. As a matter of fact, whether I agree with it or not, it's totally immaterial in the case. Whether you do or whether the Defense Attorney does, the issue is whether or not it's the law and it is.

The State of Virginia adopted that law pursuant [137] to the language of the United States Supreme Court in Roe in 1973, and this Defendant, for better or for worse, chose to do it his way.

All the conversations about what he knew or didn't know about the law, the language of the Statute is clear. We aren't talking about any novel terms that one must construe. We are talking about very simple, elemental English, terminate or attempt to terminate.

I submit on this evidence he did that and he is guilty of the offense.

CLOSING ARGUMENT ON BEHALF OF THE DEFENDANT

MR. LUCAS: Your Honor, we appreciate the attention that the Court has afforded

to the case and we feel the case is an extremely important case not only to this Defendant but important to the law as well, and it involves a great number of complex medical issues, a great number of complex legal and factual issues.

THE COURT: I appreciate the gentlemanly fashion in which all the attorneys involved have tried the case.

MR. LUCAS: Thank you, Your Honor.

* * * * * * *

In looking over the complex facts and the complex [138] law in this case, Your Honor, we see what we regard as ten strong grounds, legally or factually, on which the Court could find in the Defendant's favor.

We have argued to the Court quite ex-

tensively some of these. I will just list them and not talk about them.

The argument on the unconstitutionality of the Statute, both on its face and as applied, under the U. S. Constitution and under the Virginia Constitution.

The second argument on the vagueness of the Statute under both Constitutions and its difficulty of dealing with it in light of the Supreme Court's analysis in that Colautti v. Franklin case. That Statute there was a lot more specific than the one here.

I think if you apply that same analysis, one, not to mention the five grounds or so used in the Colautti decision which were certainly applicable to the absence of anything about specific intent, for

example.

The argument that the Statute, on its face and looking at it, is simply inapplicable to the facts here. That the Statute must be narrowly construed in favor of the Defendant in a way that protects him from the dangers of unfair notice.

[139] If it's construed so that procedure means the abortion, time of the abortion taking place, then the physician is not guilty because all the procedure that he did was a procedure which may or may not cause an abortion, a procedure that was done in his clinical facility as he very candidly testified and as the other witnesses very candidly testified.

A fourth defect would be in the In-

dictment itself. The Indictment does not negate the exception of the necessity to save the woman's life. We referred earlier to the Court United States versus Vuitch, decided by the Supreme Court in 1972.

Ironically, the Trial Court's decision dismissing the Indictment in that case was precisely ten years to the day, November 10, 1969, Judge Gerhard Gessel, on the very day that Patty McDonald was in the clinic.

I think the Supreme Court decisions on what has to be alleged by the State conclusively showed that the State must negate these types of exceptions. This isn't a self-defense situation. It's not an alibi situation and it's not an affirmative defense, but an element of the offense. Otherwise, the Commonwealth could

charge every physician with every abortion that is ever done.

* * * * * * *

[142] As a seventh ground for dismissing the charges and finding the Defendant not guilty, there is a strange mixture in the Indictment of the two Statutes. The Indictment tries to go under one Statute which certainly by itself is patently unconstitutional under the different decisions and it incorporates only part of the other elements of the offense.

It tries to include as an element of the offense some duty to the fetus, which as we have seen, is totally precluded by the Supreme Court decisions which gave rise only to that duty after viability.

On the factual aspects of the Common-

wealth's case that has been presented, factually, the Commonwealth has totally failed in producing any evidence of causation.

You can't look and find any element on those photographs proving in any way that injection of the saline solution caused either the death of the fetus or the expulsion of the fetus.

There wasn't any testimony, for example, whether the fetus would be expelled, whether there would be an abortion if the fetus died. We have heard of fetal deaths in which physicians have to instrumentally remove the fetus. There is absolutely no evidence of causation on that. [143] The hypotheticals weren't asked and the Court cannot base a finding of causa-

tion on the basis of circumstantial evidence that's of a non-medical nature and that hasn't even been tied together by an expert witness.

We submit that that creates a very serious reasonable doubt, one of the strongest reasonable doubts in this case, is the absence of this causation and the total failure of proof of causation.

With any kind of illness, any kind of situation where a person has medication or treatment, there is no guarantee that there is going to be causation. There is no guarantee it is going to cure. The person has antibiotics to cure a disease and it's not cured, the disease may have gone away because of some other reason. It may have been the wrong antibiotic. The person may

have recovered normally, spontaneously from their own bodily mechanisms.

The State perhaps could have tied that in, but they didn't even try and their proof on causation totally fails.

The scattered buckshot circumstantial evidence is simply not sufficient to support a finding of causation. [144] There is no basis for the Court, particularly to find beyond a reasonable doubt, that there is causation when there is no attempt by the Commonwealth to do so itself.

* * * * * * *

[145] Every bit of evidence indicated that Doctor Simopoulos' facility, where he practiced, was even superior to the facility in the outpatient unit at Fairfax Hospital. Every bit of the evidence indicated that his intent was to help treat this patient,

on the basis of his experience, to protect the patient's health.

The patient herself admitted problems with [146] parents and things of this nature.

There is intent, certainly, to save her from expense, intent to protect her identity from the hospital. Having her being admitted to the hospital and her identity being exposed that way, and to get her into the emergency room where she would at least have a chance of protecting her identity.

There is plenty of intent to instruct the patient postoperatively. We heard not only from the doctor, but from a nurse whom I never met until today, but also an administrator. It wasn't contrived testimony. They were very honest, very stable and very upright people and witnesses.

You didn't see any of the shifty eyes that I kept seeing from Patty McDonald when she was on the Stand.

Who was a corroborating witness for Patty McDonald? The Commonwealth wouldn't tell us. Another defect in the Commonwealth's case under Brady, at least, but we already argued that and preserved that, Your Honor.

In the long run, the final intent comes down to the intent -- the same kind of intent the good samaritan had, to help a patient, and then the patient [147] and the Commonwealth turned upon the physician in a situation, have indicted him under a law he didn't even know about, under a law that he had no reason to believe existed and then circumstances when who is the

victim.

Is there a victim? You certainly can't say the fetus is a victim. The Supreme Court dealt with that and settled that a long time ago. We could debate that endlessly. Every religion, every organization has debated it endlessly. People reach different views on that.

* * * * * * *

[148] Here it was impossible for Doctor Simopoulos to admit this patient as an inpatient to the hospital, without violating her constitutional rights by her parents being notified.

It wasn't necessary for him to. Medically, we have plenty of testimony on that and in fact the testimony on the medical safety went unchallenged and we certainly can't be accused of bringing in one unusual

expert. We brought in the leading national authority, corroborated his testimony with several local experts with plenty of experience, makes a good combination on evidence and a combination that should be valid, should be persuasive in any level of Courts, Your Honor, and the defense of necessity as well.

When the patient cannot be admitted for an injection in Fairfax Hospital, the necessity was you were going to treat her for medical care and to protect her legal and constitutional rights.

The only alternative, the only necessity, then, would be to inject the saline in your own facility. Fortunately here, the Defendant has gone even further than that necessity by having a facility which

was even better equipped than the outpatient unit at the hospital.

[149] Here again, the Commonwealth did not submit any evidence. The Commonwealth submitted no evidence, for example, on definitions of abortion, understandings in the medical profession of the word abortion. No contradiction. No doctor got up there and said that that Statute is crystal clear to me, every doctor that looked at the Statute.

I think perhaps we should have had an English teacher tell us how ungrammatical the Statute is with all its five or six different clauses, but every bit of the testimony from the witness stand concerning the Statute revealed a lot of vagueness.

I still have no idea whether a person could be prosecuted for injecting in the hospital and the patient aborting at home, something of that nature. I am still puzzled and I am sure that there are a lot of doctors that are worried about it around this community tonight.

Your Honor, on the basis of any one or all of the different points that we have raised, I think the Court could quite easily find in the Defendant's favor and would have no difficulty contending that such a finding was fully supported by the evidence and fully supported by the law. [150] As to a basis for finding in the Commonwealth's favor, I don't see any. At worst, we have got a technical, unintentional violation of an interpretation of a

Statute that the Defendant had no idea and no proof of any causation.

If there ever was a case for a finding on any one of many grounds of not guilty, Your Honor, this is that case.

* * * * * * *

[154] COURT'S FINDING

THE COURT: Doctor Simopoulos, I do find you guilty as charged in the Indictment.

* * * * * * *

[3] THE COURT: You waive your right to a presentence investigation?

THE DEFENDANT: Yes.

MR. LUCAS: Your Honor, we had filed a motion respectfully requesting the Court in effect to stay any judgement pending appeal and we had stated, and particularly

if the Court would not stay the judgement to enter a suspended imposition of sentence or a suspended sentence pending appeal, and we set out in the motion all the mitigating facts.

There are two other matters brought to my [4] attention later in the afternoon yesterday. I had a conversation with the Attorney General Assistant who represents the Medical Practice Board. He brought to my attention a very recent statute passed by the Virginia Legislature which I will hand to the Court which would require by without hearing, would require upon notice of a conviction a suspension or revocation of the physician's license by the Executive Secretary of the Board.

This could not be remedied or recti-

fied until the Board meets three months from now in July. July the 11th is the next meeting of the Board in which the Board in it's discretion could reinstate the license pending appeal.

The prior practice of the Board, it's been our understanding, that the Board would allow a physician to continue practicing pending exhaustion of all appeals.

That 1979 amendment to the statute as it's written on it's face if you handed it to the Court would eliminate that possibility, and require the physician to comply to the Board for reinstatement [5] pending appeal.

This is a very harsh, and difficult situation to impose upon the physician. We also have the medicaid memo indicating

that he could not see any maternity patients, any of the medicaid maternity patients that he has been seeing, nor provide them with any continuity of care because upon a conviction that the medicaid participation in the medicaid program is ultimately terminated, and only if there is a reversal upon appeal then you may apply for reinstatement.

Those are two additional, very harsh considerations.

This would deprive Doctor Simopoulos of his livelihood, deprive his family of support.

* * * * * * *

[10] There was no evidence that it was not a medically sound procedure nor was it administered in a place that was unhealthy;

to the contrary, all the evidence including that of the detective was that Doctor Simopoulos ran his business in a clean, fair, open manner, and that in fact, if you believe Doctor Soyster and the other imminent doctors, his clinic is better equipped than a hospital, it's just that it's not "licensed" as a hospital.

* * * * * * *

[12] MR. HORAN: If Your Honor please.

I have a recommendation I would like to make to the Court. I'll be brief as possible.

I'd like to put this case a little bit into a historical perspective because I want the Court to know why I'm making the recommendation that I'm making.

In 1848 in the case of Sanford versus

Scott the United States Supreme Court decided that a black man named Dred Scott was not a person within the meaning of the American Constitution. I'm a little bit appalled that the Court would say that but in its wisdom it said that.

In 1973 Mr. Justice Harry Blackmun, speaker for the majority of the Supreme Court, said that a fetus is not a person within the meaning of the American Constitution.

That decision by Blackmun makes this a victimless crime.

Now, I may not like that. As a human being [13] I may reject that, but as a prosecutor I am bound by that, and I accept that as a legal matter, and I accept it for the purposes of this sentencing.

We are dealing with a victimless crime. Five and a half months of gestational age do not qualify under the wisdom of Mr. Justice Blackmun.

We live in interesting historical times, and there's a thing that happened recently that is kind of similar to what goes on here, and the position that the Defendant finds himself in.

In 1935 the Supreme Court of the United States in a Virginia case of Carrie Buck versus Bell, a decision written by Oliver Wendell Holmes said three generations of idiots are enough, go ahead and sterilize Carrie Buck, and they did, and for 20 years thereafter in Lynchburg training school and other mentally retarded hospitals in Virginia they sterilized retarded

people.

Recently, there has been a great furor about that they were doing this in Virginia and the United States Supreme Court said they could do [14] it and they're doing it.

This Defendant is somewhat in the position of those doctors. The doctors at Lynchburg who for 20 years sterilized people because the Supreme Court of the United States told them it was all right to do it is similar to the situation to where Harry Blackmun says it's all right to abort second trimester fetuses before the United States stated it is all right, this Defendant is somewhat in that position.

He's like the guys at Lynchburg training school. What he didn't do is read the

whole decision that said that in the second trimester the State could adopt certain provisions. The State has done that. This Defendant for reasons best known to himself decided not to do it the way the State said to do it.

All of that by way of preamble, Your Honor, to suggest to the Court that the Commonwealth accepts since 1973 this offense is victimless.

Since 1973 the states only have the right to say how you will do it. The Supreme Court said it is all right to do it.

[15] This Defendant did not accept the way Virginia said how to do it. Current wisdom is for victimless crimes is the Defendant is somewhat in the situation of

somebody illegally in possession of gambling slips or illegally in possession of obscene literature.

He's engaged in victimless activity according to the law. Current wisdom is that community service makes sense in these kinds of cases.

It would be the recommendation of the Commonwealth that he receive a suspended penitentiary sentence and the Court order him to perform some type of community service.

* * * * * * *

[16] THE COURT: Stand up, Doctor. Is there anything that you would like to say before I impose sentence?

THE DEFENDANT: Yes, Your Honor. I would like to respectfully request this

Court to take into consideration a few factors.

I've been a law abiding citizen all my [17] life. I do strongly believe in the Constitution of the Republic and the laws of the Commonwealth of Virginia.

If I did, indeed, violate certain laws of the Commonwealth I did so quite unintentionally and in an effort to help a fellow human being in dire need under the most adverse circumstances.

I'm a family man, a husband, and father to four sons. I believe my sons have been subjected to unusual punishment as a result of this legal entanglement of mine.

They're quite innocent, and I don't think they should bare (sic) the burden of my mistakes.

Also, as a human, as a physician, as a doctor, I would like to once again devote my full energy mine (sic) and hard (sic) to the practice of my medicine.

I'm afraid, however, that unless you suspend your findings of guilt I will be required by law to abandon my medicaid maternity patients for the mercy, dear God, and expose them to unforeseen medical complications which may very well result from not having any adequate [18] prenatal care.

These poor and unfortunate women who will never be able to find another obstetrician in all of Northern Virginia to care for them. That's all I have to say, Your Honor.

THE COURT: Well, Doctor, I want you

to understand that I've considered and why I'm going to sentence you.

So far as keeping your medical license I really have no control over that at all. That's up to the other doctors on the Medical Board, and I'm taking no position whatsoever on that.

If they determine that you should keep your license then that would be fine with me. I'm not refusing your counsels (sic) request to suspend imposition of sentence because I want them to take your license that's up to the medical profession.

Insofar as your defense of not knowing the law maybe that's true I have a very, very difficult time believing it, that a man who is in fact in the abortion business doesn't know what the [19] laws are con-

cerning his profession.

There are only four or five of them in Virginia.

Insofar as being sentenced for killing a baby or killing a person or things of that nature which have been brought out I'm certainly not sentencing you for that, regardless of whether I think it's wrong to do it or right to do it makes no difference.

The Supreme Court and the Virginia Legislature have said it's okay, and I accept that, and I look at your case as really one where you were doing that which you had a legal right to do, but you weren't following what I consider legitimate regulations handed down by the legislature of Virginia (sic)

I recognize the factthat your clinic has been described by the witnesses here as being certainly more than adequate. I'm not sure that everyone performing these procedures would have that sort of clinic, and I think that the State of Virginia has a legitimate interest in providing for the health of these patients, and requiring [20] that it be done in a hospital, and I'm not going to make a big speech to you. I'm just trying to tell you the things I'm considering.

* * * * * * *

I'm looking at the fact that you have no prior record. I believe you are a good family man. You have four young children. I believe you're a good church-man, Saint Catherines as the Father testified to.

Probably, most impressive to me personally is the fact that you're a boy who came from illiterate parents in the mountains of Macedonia, and got through the University of Athens Medical School. For my understanding of the particular achievement it's probably equivalent to a share-cropper's kid from South Carolina in the 30's getting through Harvard. It's something to be proud of.

* * * * * * *

[21] I do sentence you to two years in the penitentiary. I suspend the entire two years conditioned on your serving 30 days in the Fairfax County Jail, that time to be served on weekends Saturday at 8:00 a.m. to Sunday 8:00 p.m., and place you on two years inactive probation.

* * * * * * *

THE COURT: Well, I will suspend execution of this sentence pending any appeals and will continue the present bond that the Doctor has. Thank you very much.

Appendix

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ALEXANDER L. STEVAS
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No. 81-185

In The

Supreme Court of the United States

October Term, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Appellant,

vs.

COMMONWEALTH OF VIRGINIA,
Appellee.

Appeal from the Supreme Court of Virginia

ADDENDUM OF MEDICAL/STATISTICAL/LEGAL DOCUMENTS LODGED WITH BRIEF FOR APPELLANT

ROY LUCAS
Counsel of Record
LUCAS & ASSOCIATES, P.C.
Three Ten Constitution Avenue, N.E.
Washington, D.C. 20002
(202) 543-5115

WILLIAM P. MARSHALL
1515 Hague Avenue
St. Paul, Minnesota 55104
(612) 644-5145

Attorneys for Appellant

JOHN H. OBRION
BROWDER, RUSSELL, LITTLE,
MORRIS & BUTCHER
Of Counsel

7095
LUTZ APPELLATE PRINTERS, INC.
NY (212) 840-9494 • (516) 222-1606 • (914) 683-9363
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Document Number	Pages in Addendum	Author, Title, Citation, Description
		SCIENTIFIC PUBLICATIONS
1.	[1]-[4]	LeBolt, et al., Mortality From Abortion and Childbirth:Are the Populations Comparable?, 248 J.A.M.A. 188 (1982) (compares relative safety of terminating pregnancy versus continuing)
2	[5]-[14]	Henshaw, et al., Abortion Services in the United States, 1979 and 1980, 14 Family Planning Perspectives 5-15 (1982) (numbers and availability of abortion services)
3	[15]-[17]	Abortion: Need, Services and Policies, Virginia, The Alan Guttmacher Institute (1979) (summary of findings on abortion practices in Virginia for most recent year studied)
4	[18]-[23]	Schulman, Outpatient Saline Abortion, 37 Obstetrics & Gynecology 521 (1977) (study of feasibility of outpatient instillation practice)
5	[24]-[28]	Soderstrom & Hayden, Outpatient Saline Abortion: a Review of 1,000 Cases, 12 Advances in Planned Parenthood 98 (1977) (data on large number of outpatient saline procedures)

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* Documents are cited in the brief by author, title, and a page reference to this Addendum. E.g., Schulman, Outpatient Saline Abortion (ADDENDUM 18).

6	[29]-[34]	Grimes, The Brief for Hypertonic Saline, 15 Contemporary Ob/Gyn 29-38 (June 1980) (a comparison of saline and prostaglandin techniques)
7	[35]-[50]	Kerenyi, Outpatient Intra-amniotic Injection of Hypertonic Saline, 14 Clin. Obst. & Gyn. 137 (1971) (non-hospital saline abortion study in New York)
8	[51]-[56]	S. Neubardt & H. Schulman, Techniques of Abortion 65, 99-104 (1972) (textbook chapter on second trimester saline instillation procedure)
9	[57]-[59]	Shelton, Abortion Utilization: Does Travel Distance Matter, 8 Family Planning Perspectives 260 (1976) (study of travel impact as a burden on access to abortion)
10	[60]-[66]	Nathanson, Obstetricians' Attitudes and Hospital Abortion Services, 12 Family Planning Perspectives 26 (Jan./Feb. 1980) (studies hospital policies on abortion)
11	[67]-[74]	Hospital Mortality, P.A.S. Hospitals, United States, 1974-75, Table D: Ranking of Operation Groups by Fatality Rate, Number of Patients, and Number of Deaths 298-311 (1977) (compares mortality rates of 225 operations)
12	[75]-[79]	Grimes, et al., Methods of Midtrimester Abortion: Which Is Safest? 15 Int. J. Gyn. & Obst. 184 (1977) (compares D & E, saline, and prostaglandin)

GUIDELINES / STANDARDS / DECISIONS

13	[80]-[81]	American Public Health Association Resolution, "The Right to Second Trimester Abortion," (Adopted November, 1979)
14	[82]-[86]	Simopoulos v. Virginia State Bd. of Medicine, No. 80-1431 (4th Cir. 1980) (not reported), vacated on other grounds, 644 F.2d 321 (4th Cir. 1981) (decision restoring medical license pending further proceedings)
15	[87]-[91]	Planned Parenthood v. Ashcroft, 664 F.2d 687 (8th Cir. 1981), cert. granted, ___ U.S. ___ (1982) (Nos. 81-1255 & 81-1623)
16	[92]-[111]	Akron Center v. City of Akron, 651 F.2d 1198 (6th Cir. 1981), cert. granted, ___ U.S. ___ (1982) (Nos. 81-746 & 81-1172)
17	[112]-[121]	Gary-Northwest v. Orr, 496 F.Supp. 894 (N.D. Ind. 1980) (three-judge court), aff'd mem., 451 U.S. 934 (1981)
18	[122]-[167]	Margaret S. v. Edwards, 488 F.Supp. 181-186, 191-196 (E.D. La. 1980) (not appealed) (Louisiana second trimester hospital mandate held unconstitutional)
19	[168]-[178]	Mucie v. Gourley, Civ. No. 73 CV 497-W-3 (W.D. Mo. 1977) (not reported, not appealed)

Mortality From Abortion and Childbirth

Are the Populations Comparable?

Scot A. LeBolt; David A. Grimes, MD; Willard Cates, Jr, MD, MPH

• **Critics have challenged previous comparisons of mortality from legal abortion and childbirth for contrasting population groups with different clinical characteristics. They allege that most women dying from abortion were young, white, and healthy, while those dying from childbirth had serious underlying conditions. To address this question, we calculated standardized abortion and childbirth mortality rates between 1972 and 1978. We also adjusted independently for preexisting medical conditions. These adjustments for demographic and health differences between the two populations actually widened the difference in the mortality risk between abortion and childbirth. Thus, between 1972 and 1978, women were about seven times more likely to die from childbirth than from legal abortion, with the gap increasing in the more recent years.**

(*JAMA* 1982;248:188-191)

OUR COMPANION article (p 192) addresses the issue of whether the crude data comparing mortality from legal abortion and childbirth for the woman contained statistical biases favoring the safety of abortion; we conclude they did not. Rather, the crude data between 1972 and 1978 appear to overestimate the abortion risks for the woman, compared with the risks of childbirth.

See also p 192.

However, another separate allegation by some critics[1,2] is that the populations of women dying from either abortion or childbirth are not clinically comparable. These critics claim that most women who died from abortion were young, white, and healthy and that those who died from continuing their pregnancies to term had serious underlying medical conditions. We undertook this study to address this question and also to update our previous data.[3,4] In this report we present standardized abortion and childbearing mortality rates between 1972 and 1978. We also adjusted independently for the presence of preexisting conditions. These more recent data corroborate that, in terms of risk of death, abortion is safer than childbearing.

From the Family Planning Evaluation Division, Center for Health Promotion and Education, Centers for Disease Control, Atlanta.

Reprint requests to the Family Planning Evaluation Division, Center for Health Promotion and Education, Centers for Disease Control, Atlanta, GA 30333 (Dr Grimes).

METHODS

The various sources of data for comparing mortality from legal abortion and childbearing are described in detail in the companion article (p 192). For this analysis, we used the number of abortion-related deaths from the Centers for Disease Control's (CDC) ongoing nationwide surveillance of abortion mortality[5]; we used as a denominator the total number of abortions reported by the Alan Guttmacher Institute (AGI).[6] We applied the annual CDC distributions of age and racial characteristics of women obtaining abortions[7] to the AGI totals to estimate distributions of abortions by age and race for each year.

We obtained all data on maternal deaths and live births in the United States from the national vital statistics system of the National Center for Health Statistics.[7,8] To determine the number of deaths from childbearing, we excluded all abortion-related deaths and deaths from ectopic pregnancies from the total number of maternal deaths. We calculated the childbearing mortality rate as the number of these deaths per 100,000 live births. The effect of excluding deaths from abortion and ectopic pregnancy from maternal deaths in calculating childbearing mortality rates presents a conservative estimate of this risk.

We used two independent approaches to control for potential differences between our comparison populations of women terminating pregnancy *v* women continuing their pregnancies to term. We first adjusted for demographic characteristics by standardizing both the abortion and the childbearing mortality rates directly

Table 1.—Death-to-Case Rates for Legal Abortion, by Year, Age, and Race, 1972 Through 1978

Characteristic	No. of Deaths	No. of Abortions*	Rate†
Year			
1972	24	587,000	4.1
1973	25	745,000	3.4
1974	25	899,000	2.8
1975	29	1,034,000	2.8
1976	11	1,179,000	0.9
1977	17	1,317,000	1.3
1978	7	1,410,000	0.5
Age, yr			
≤19	29	2,292,000	1.3
20-24	49	2,382,000	2.1
25-29	28	1,314,000	2.0
30-34	17	689,000	2.5
≥35	17	494,000	3.4
Race			
W	65	4,975,000	1.3
B and other	73	2,195,000	3.3
Total	138	7,170,000	1.9

*Specific numbers may not add to total due to rounding.
†Deaths per 100,000 abortions.

Table 2.—Childbearing* Mortality Rates by Year, Age, and Race, 1972 Through 1978

Characteristic	No. of Deaths	No. of Live Births†	Rate‡
Year			
1972	494	3,258,000	15.2
1973	395	3,137,000	12.6
1974	383	3,160,000	12.1
1975	326	3,144,000	10.4
1976	333	3,168,000	10.5
1977	309	3,327,000	9.3
1978	268	3,333,000	8.0
Age, yr			
≤19	352	4,144,000	8.5
20-24	582	7,855,000	7.4
25-29	827	8,852,000	9.4
30-34	479	2,807,000	17.1
≥35	468	1,070,000	43.7
Race			
W	1,525	18,274,000	8.3
B and other	983	4,253,000	23.1
Total	2,508	22,527,000	11.1

*Excludes death from abortion and ectopic pregnancy.
†Specific numbers may not add to total due to rounding.
‡Deaths per 100,000 live births.

by age, race, and year. We then adjusted independently for health status by calculating risk-specific death-to-case rates for legal abortion and comparing them with published data on maternal mortality.

For our demographic comparison, we used the method of direct standardization[9] to adjust mortality rates. Age-, race-, and year-specific rates were each directly standardized by the other two variables. We used as our reference population the distributions of the white women 19 years old or younger obtaining abortion in 1972, respectively, for each of the standardized rates.

For our health status comparison, we used the criteria suggested by Nathanson[10] to determine which preexisting conditions were considered so potentially life threatening that they justified a therapeutic abortion. We determined the prevalence of these conditions among women who died from legal abortion in 1972 through 1978 by reviewing individual case reports of deaths. Detailed clinical information about 114 of the 138 abortion-related deaths was available for analysis. The prevalence rate for preexisting conditions (34%) among the 114 abortion deaths was applied to the 24 abortion deaths lacking this information.

No reliable nationwide data are available for denominators on the prevalence of preexisting conditions among women undergoing either abortion or childbearing. To estimate the prevalence of preexisting conditions among all women obtaining abortions in 1972 through 1978, we used the rates of women with preexisting conditions in hospital and nonhospital facilities that participated in our large multicenter study conducted from 1971 through 1975.[11]

Table 3.—Death-to-Case Rates for Legal Abortions and Corresponding Childbearing Mortality Rates, by Year, Age, and Race, 1972 Through 1978

	Abortion Rate*		Childbearing Rate†		Relative Risk‡
	Crude	Standardized	Crude	Standardized	
Year					
1972	4.1	4.1	15.2	16.8	4.1
1973	3.4	3.2	12.6	13.9	4.3
1974	2.8	2.8	12.1	13.9	5.3
1975	2.8	2.8	10.4	12.0	4.6
1976	0.9	0.8	10.5	11.7	14.6
1977	1.3	1.2	9.3	10.4	8.7
1978	0.5	0.4	8.0	9.1	22.8
Age, yr					
≤19	1.3	1.3	8.5	7.7	5.9
20-24	2.1	2.1	7.4	7.9	3.8
25-29	2.0	2.0	9.4	11.6	5.8
30-34	2.5	2.3	17.1	20.1	8.7
≥35	3.4	3.2	43.7	46.3	14.5
Race					
W	1.3	1.3	8.3	8.2	6.3
B and other	3.3	3.5	23.1	23.1	6.6
Overall	1.9	1.8	11.1	12.5	6.9

*Deaths per 100,000 abortions.
†Deaths per 100,000 live births.
‡Ratio of standardized childbearing rate to standardized abortion rate.

We applied these rates to the total number of abortions performed throughout the country in each type of facility during the seven-year interval. Using this approach, we estimated 1.3% of women obtaining abortions between 1972 and 1978 had preexisting conditions.

RESULTS

Secular Trends

One hundred thirty-eight women died from legal abortion from 1972 through 1978. Between 1972 and 1975, the annual number of abortion-related deaths remained stable, with a mean of 25.8±1.9 (SD of population). After 1975, the number of deaths declined to a mean of 11.7±4.1 (SD of population) (Table 1). This trend of decreased deaths in later years, combined with the progressively increasing number of abortions performed, has led to a 72% reduction in the crude death-to-case rates, from 3.2 deaths per 100,000 abortions for the years 1972 through 1975 to 0.9 deaths per 100,000 abortions for 1976

Table 4.—Serious Preexisting Medical Conditions Among Women Who Died From Legal Abortion, 1972 Through 1978

Condition	No.	%
One or more	39	34.2
Chronic heart disease	13	11.4
Obesity*	11	9.6
Hypertension†	6	5.3
Chronic respiratory tract disease	3	2.6
Chronic renal disease	3	2.6
Sickle cell disease	1	0.9
Chronic degenerative CNS disease	1	0.9
Thromboembolic disease	1	0.9
None	75	65.8
Total	114	100.0

*These women were a mean 70.6% ± 17.5% over ideal body weight for height according to Metropolitan Life tables.

†These women each had a systolic BP of 130 mm Hg or higher and a diastolic BP of 90 mm Hg or higher.

Table 5.—Estimated Death-to-Case Rates for Legal Abortion, by Preexisting Medical Conditions, 1972 Through 1978

Medical Status	No. of Deaths	No. of Abortions	Rate*
No serious preexisting medical conditions	91	7,077,000	1.3
One or more serious preexisting medical conditions	47	93,000	50.5
Total	138	7,170,000	1.9

*Deaths per 100,000 abortions.

through 1978 (Table 1). In contrast, the number of childbearing deaths has declined steadily, but at a slower pace (Table 2). This more gradual decline, coupled with the relatively constant number of births, has led to a 26% reduction in the crude childbearing death-to-case rate, from 12.6 per 100,000 live births in 1972 through 1975 to 9.3 per 100,000 live births in 1976 through 1978.

During the entire study interval, the standardized relative risk of childbearing was sevenfold higher than the standardized relative risk of abortion (Table 3). Because of the steep decline in the abortion death-to-case rate, this gap actually widened after 1975.

Demographic Factors

In general, younger women had lower death-to-case rates from either pregnancy outcome than did older women (Tables 1 and 2). The lowest rates were in the 19-years-or-younger age group of women obtaining abortions and in the group of women aged 20 to 24 years undergoing childbearing. Women aged 35 years or older had the highest rates for both groups. For all ages, childbearing had a higher risk of death than abortion. After standardization, the death-to-case rate for women 35 years or older who underwent childbearing was nearly 15-fold greater than for those who obtained abortion (Table 3).

Women of minority races were at a greater risk of death than white women for both pregnancy outcomes (Tables 1 and 2). Women of black and other races obtaining abortion had a mortality rate 2.5 times higher than white women (Table 1). Similarly, women of black and other races were 2.8 times more likely to die from childbearing than were white women (Table 2). For both racial groups, legal abortion had a lower mortality rate than childbearing (Table 3).

Preexisting Conditions

More than one in three women who died from legal abortion between 1972 and 1978 had preexisting medical conditions serious enough to qualify them for therapeutic abortions under Nathanson's criteria (Table 4). Chronic heart disease and morbid obesity were the two predominant preexisting conditions. However, hypertension, chronic respiratory tract disease, and chronic renal disease each occurred in at least three of the abortion-related deaths.

The death-to-case rate from legal abortion for women with one or more preexisting conditions was 39 times higher than that for healthy women (Table 5). Women with medical problems severe enough to justify abortion had a death-to-case rate of more than 50 per 100,000 procedures, compared with the rate of 1.3 for healthy women.

COMMENT

Deaths after legally induced abortions have fallen sharply since 1975, in contrast with the gradual decline in childbearing deaths. During our study interval, the number of legal abortions has increased progressively while that of live births has remained constant. Consequently, the difference between the risk of death from childbearing *v* the risk of death from legal abortion has widened from fivefold in 1972 through 1974[1] to more than tenfold in 1976 through 1978. During the most recent three-year interval, abortion has become even safer compared with childbearing.

As demonstrated in our companion article, these comparisons probably underestimate the relative safety of abortion for pregnant women. The CDC's surveillance techniques apparently identify 94% of all abortion-related deaths, while traditional vital statistics systems detect 50% to 75% of childbearing-related deaths. Abortion deaths, therefore, appear more likely than childbearing deaths to be reported completely. The abortion death-to-case rate would be correspondingly larger based on differential ascertainment.

We directly standardized the death-to-case rates to control for potentially distorting demographic factors. After this standardization, the relative risk of childbearing increased compared with abortion; the unadjusted relative risk of childbearing compared with abortion was 5.8, while the adjusted relative risk was 6.9. This difference occurs because relatively fewer women of the higher-risk ages and races are in the childbearing population. For example, 31% of women in the abortion population were of black and other races, in contrast to only 19% in the childbearing population. Adjusting the rates to the same population raises the risk for childbearing compared to abortion.

Gestational age is an important

risk factor for deaths after legal abortion.[14] However, as our previous analysis demonstrated,[4] the technique of standardization primarily affects comparisons among other categories of abortion mortality (such as age, race, and year). The crude and standardized rates were similar for gestational age and had little effect on comparisons between abortion and childbearing. To reflect more accurately the independent risk of increasing gestational age, a life-table analysis of pregnancy-related mortality rates would be preferable.[12]

For a proxy, we can use gestational age-specific death-to-case rates for women dying from abortion during our seven-year study interval.[1] At eight or fewer weeks' gestation, when more than half the procedures are performed, the risk of death from abortion was more than 20 times lower than that of childbearing. This difference declines as gestational age increases, but abortion remains the safer procedure with respect to the woman's life at gestational ages at least up through 16 weeks.

A recent analysis[3] has attempted to compare mortality risks of induced abortion and "natural pregnancy" in the first and second 20 weeks of pregnancy; it concluded that natural pregnancy was safer in both intervals.[3] However, this analytic approach fails to recognize that the woman who has successfully completed the first 20 weeks of pregnancy is still at risk of death in the next 20 weeks.[13] A woman obtaining an induced abortion, however, is obviously not subject to the risks of continuing her pregnancy to term.

Approximately one third of women who died from legal abortion between 1972 and 1978 had medical conditions serious enough to meet Nathanson's criteria for therapeutically terminating a pregnancy. However, his criteria do not include such conditions as diabetes mellitus, thrombophlebitis, and multiple sclerosis. Because these conditions were excluded, we believe our estimate of 34% of women dying from abortions having serious preexisting conditions to be somewhat conservative (Table 4).

Women with Nathanson's preexisting conditions had an abortion-related mortality rate nearly 40 times that of women without them. Confounding factors alone cannot account for this large difference, since the distribution of the women's age, race, and gestational age was relatively similar between the two groups. Women with preexisting conditions dying from abortion were slightly older than healthy women dying from abortion (mean ages, 28 and 24 years, respectively), but this difference is neither statistically nor clinically significant. The gestational age was nearly identical for the two groups, being 15.0 menstrual weeks for women with preexisting conditions and 14.6 for women without preexisting conditions. Similarly, the racial distribution for women with and without preexisting conditions was comparable, 49% and 45% being white, respectively.

If the women with preexisting conditions are removed from analysis, the death-to-case rate for legal abortion is lowered considerably. For example, the aggregate death-to-case rate from 1972 through 1978 drops from 1.9 deaths per 100,000 abortions to 1.3 deaths per 100,000 abortions. During the most recent three years, healthy women had a death-to-case rate of six deaths per 1 million abortions. The best estimate, therefore, of the current risk of dying from legal abortion for healthy women in the United States is less than one per 100,000 procedures.

No national data exist to allow calculation of the risk of childbearing for women with and without serious preexisting conditions. For purposes of comparison, however, approximately 14% of women who died from childbearing in New York State between 1970 and 1976 appear to have had one or more of Nathanson's preexisting conditions.[14] If New York State data are representative of childbearing deaths elsewhere, more women dying from abortion than those dying from childbearing had serious preexisting medical conditions. This might occur if ill women, on their physician's advice, opted to terminate their pregnancies for therapeutic reasons. Thus, contrary to some assertions,[1] pregnant women with serious preexisting health problems may be more likely to terminate their pregnancies through induced abortion than to continue their pregnancies to term. Therefore, comparative mortality data may be spuriously weighed against abortion.

CONCLUSION

Neither demographic nor health factors account for the lower risks of death from legal abortion compared with death from childbearing. Adjusting for these variables increases the apparent magnitude of the relative safety of abortion. The risk of a healthy woman's dying from elective abortion is extremely rare; in 1972 through 1978 her risk was approximately one per 100,000 abortions. Women with serious preexisting conditions have a greatly increased mortality rate regardless of the pregnancy outcome. However, even for these women, abortion is probably the safest option in terms of mortality risks.

References

1. Testimony of T. W. Hilgers, given before the Royal Commission on Human Relationships, May 21, 1975, Sydney, Australia, reprinted in *Hearings Before the Subcommittee on Constitutional Amendments of the Senate Subcommittee on the Judiciary*, 94th Cong, 1st sess, part IV, 1975, p 724.

2. Hilgers TW, O'Hare D: Abortion-related maternal mortality: An in-depth analysis, in Hilgers TW, Horan DJ, Mall D (eds): *New Perspectives in Human Abortion*. Frederick, Md, Aletheia Books, University Publications of America Inc, 1981, pp 69-91.

3. Cates W Jr, Grimes DA, Smith JC, et al: Legal abortion mortality in the United States: Epidemiologic surveillance, 1972-1974. *JAMA* 1977;237:452-455.

4. Cates W Jr, Tietze C: Standardized mortality rates associated with legal abortion: United States, 1972-1975. *Fam Plann Perspect* 1978; 10:109-112.

5. *Abortion Surveillance, 1978*, US Dept of Health and Human Services publication 80-8276. Atlanta, Centers for Disease Control, November 1980.

6. Henshaw S, Forrest JD, Sullivan E, et al: Abortion in the United States, 1978-1979. *Fam Plann Perspect* 1981;13:6-18.

7. *Vital Statistics of the United States*, National Center for Health Statistics. Government Printing Office, 1972-1978, vol 2: *Mortality*.

8. *Vital Statistics of the United States*, National Center for Health Statistics. Government Printing Office, 1972-1978, vol 1: *Natality*.

9. Spiegelman M, Marks HH: Indexes of mortality and tests of their statistical significance. *Hum Biol* 1966;38:280-292.

10. Nathanson BN: *Aborting America*. New York, Doubleday & Co Inc, 1979, pp 244-247.

11. Cates W Jr, Schulz KF, Grimes DA, et al: The effect of delay and choice of method on the risk of abortion morbidity. *Fam Plann Perspect* 1977;9:266-273.

12. Rohr LH, Sherwin R, Henderson MM: The impact of legal abortion: Redefining the maternal mortality rate. *Health Serv Rep* 1974;89:267-273.

13. Cates W Jr: Abortion myths and realities: Who is misleading whom? *Am J Obstet Gynecol* 1982;142:954-956.

14. McLean R, Mattison ET, Cochrane NE: Maternal mortality study: I. Annual report, 1970-1976. *NY State J Med* 1979;79:29-46.

Document #2

Abortion Services in the United States, 1979 and 1980

By Stanley K. Henshaw, Jacqueline Darroch Forrest, Ellen Sullivan and Christopher Tietze

Summary

• There were 1.55 million legal abortions in the United States in 1980. About three percent of the 53 million women of reproductive age obtained an abortion, and one-fourth of pregnancies—a little less than half of all that were unintended—were terminated by abortion.

• While the abortion rate is increasing somewhat, the increases have become progressively smaller over the years. The rate increased by two percent between 1979 and 1980, compared with an increase of four percent between 1978 and 1979, and with larger increases in previous years. If these trends continue, the abortion rate may be expected to stabilize at 1980 levels or to rise only slightly. Several factors help account for the continuing increase in the abortion rate.

• The most important factor influencing the increase since 1975 appears to be a rise in the rate of unintended conceptions. This increase is attributable mainly to a sizable shift from use of the most effective reversible methods of contraception, the pill and the IUD, largely as a result of reports of serious although rare health consequences associated with their use.

• Geographic availability of abortion services increased slightly between 1978 and 1980, despite the heightened public controversy over abortion (which might have been expected to have a chilling effect upon potential providers). Nonetheless, abortion services are still not readily available to all women. Seventy-eight percent of all U.S. counties had no identified abortion service provider in 1980, and 28 percent of women of reproductive age lived in these counties.

• Fifty-nine of the nation's 305 standard metropolitan statistical areas (SMSAs), which contain cities of substantial size, had no facility providing abortions, and an additional 25 SMSAs reported fewer than 50 abortions in 1980.

• Three-fourths of all abortions in 1980 took place in the 459 clinics and hospitals that provided 1,000 or more abortions each, although abortions were reported in 2,758 different facilities.

• Almost 80 percent of all abortions were performed in nonhospital facilities in 1980, compared with fewer than 50 percent in 1973. The proportion performed in hospitals dropped from a high of 52 percent in 1973 to just 22 percent in 1980. Among the reasons for this change in type of provider is that improvements in and simplifications of the technology by means of which abortions can be performed safely have made services in freestanding facilities an increasingly practical and suitable option, far less costly than hospital-based services.

• About one in 10 obstetrician-gynecologists in private practice performed abortions in their offices 1980.

Factors in addition to limitations on geographic availability that restrict women's access to abortion services are

• the lack of Medicaid funding for most abortions in all but 14 states and the District of Columbia, affecting the poorest women;

• parental notification and consent requirements imposed by 19 percent of abortion clinics and by law in seven states (although the constitutionality of such legislative requirements is being challenged in the courts);

• the fact that 30 percent of abortion providers perform abortions only at 10 or fewer weeks' gestation and that only 21 percent perform abortions after 14 weeks, as measured from the last menstrual period;

• the absence of outpatient abortion services

About one-fourth of all pregnancies, just under one-half of all that were unintended, were terminated by abortion in 1980. Increases in the abortion rate, which was 30.0 per 1,000 live births in 1980, are slowing; if the trend continues, the abortion rate should stabilize this year.

Abortion in a freestanding clinic. About 8 in 10 terminations occurred in such facilities in 1980.

Stanley K. Henshaw is Senior Research Associate, Jacqueline Darroch Forrest is Director of Research and Ellen Sullivan is Research Associate with The Alan Guttmacher Institute. Christopher Tietze, a member of the Institute's Science Advisory Panel, is Senior Consultant with The Population Council and directs its abortion research activities. The survey on which this article is based was supported in part by grants from The George Gund Foundation, The Huber Foundation and The David and Lucile Packard Foundation. Details of the methodology and detailed tables may be found in S. Henshaw, J. D. Forrest, E. Sullivan and C. Tietze, *Abortion 1979–1980: Need & Services in the United States, Each State & Metropolitan Area*, The Alan Guttmacher Institute, New York, 1982 (forthcoming).

Table 1. Number of reported abortions and number of facilities, by metropolitan status; rate of abortions per 1,000 women aged 15–44; and ratio of abortions per 1,000 abortions plus live births; United States, 1973–1980

Measure and metropolitan status	1973	1974	1975	1976	1977	1978	1979	1980* (Proj. pop.)	1980† (Census)
(1) No. of abortions (000s)									
Total	744.6	898.6	1,034.2	1,179.3	1,316.7	1,409.6	1,497.7	1,553.9	1,553.9
Metro	720.2	860.7	985.7	1,123.3	1,258.0	1,345.2	1,430.9	1,483.9	1,507.7
Nonmetro	24.4	37.9	48.5	56.0	58.7	64.4	66.8	70.0	46.2
(2) No. of facilities									
Total	1,627	2,028	2,398	2,567	2,688	2,753	2,734	2,758	2,758
Metro	1,302	1,615	1,903	2,036	2,139	2,198	2,213	2,244	2,318
Nonmetro	325	413	495	531	549	555	521	514	440
(3) Abortion rate	16.6	19.6	22.1	24.5	26.9	28.2	29.3	30.0	29.4
(4) Abortions per 1,000 abortions plus live births‡	193	220	249	265	286	294	297	300	300

*Metropolitan status and population estimates comparable to those used for 1979 calculations. See † on page 7.

†Metropolitan status and population estimates based on 1980 census. The April 1, 1980, census count was used since projections were not available for July 1, 1980, national and state populations by sex and age. It is estimated that the abortion rate based on the July 1 population would be 29.3.

‡For each year, births occurring during the 12-month period starting in July of that year (to match time of conception of pregnancies ending in births with that of pregnancies ending in abortions).

Sources: **1973–1978—see reference 2; 1979–1980 abortion and provider data**—AGI abortion survey; **population data**—U.S. Bureau of the Census, "Estimates of the Population of the United States, by Age, Race, and Sex: 1976–1979," *Current Population Reports*, Series P–25, No. 870, 1980, Table 2; ——, "Projections of the Population of the United States: 1977 to 2050," *Current Population Reports*, Series P–25, No. 704, 1977, Table 8; and ——, "Age, Sex, Race, and Spanish Origin of the Population by Regions, Divisions, and States: 1980," *Supplementary Reports*, PC80–S1–1, 1981; **birth data**—National Center for Health Statistics, DHHS, "Births, Marriages, Divorces, and Deaths for June 1981," *Monthly Vital Statistics Report*, Vol. 30, No. 6, 1981.

in 45 percent of the hospitals that provide abortions; and

• the practice of 74 percent of hospitals reporting abortions not to accept abortion patients directly but to require that they be referred by an attending physician.

Introduction and Methodology

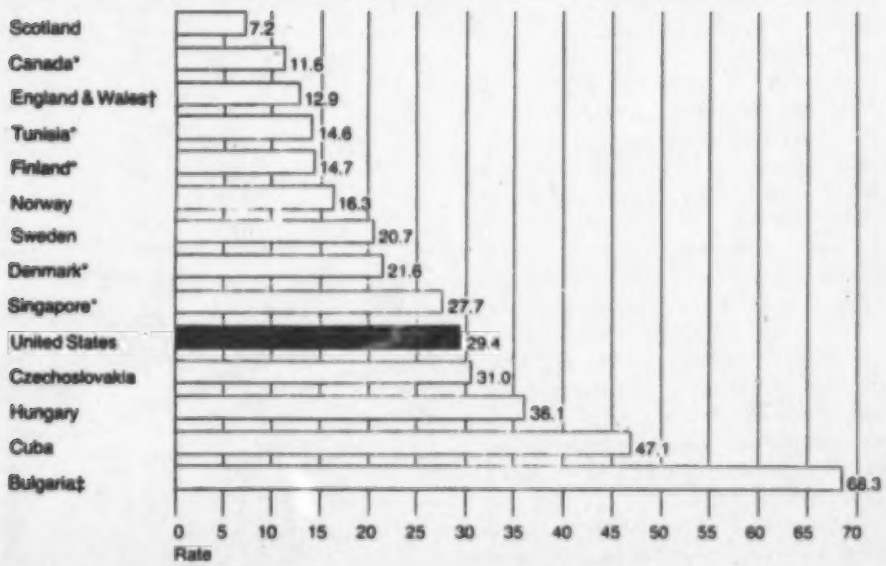
Since the 1973 Supreme Court rulings legalizing abortion in the United States, The Alan Guttmacher Institute (AGI) has monitored the availability and accessibility of abortion services throughout the country through national surveys of all known providers of abortion services—public and private hospitals, freestanding clinics and private physicians. The data thus obtained provide the only national information on the number of abortion service providers and the numbers of abortions by geographic area and by type of facility. This article describes some of the results of the AGI's seventh abortion survey, fielded in the spring and summer of 1981 and covering two years, 1979 and 1980. In this article, we will concentrate on the availability and accessibility of abortion services according to such factors as geographic concentration of services, types of facilities, Medicaid funding, parental notification and consent restrictions, acceptance of self-referred patients and limits on the gestational age at which abortions are performed.

In the 1981 survey, providers were asked to report the number of abortions performed in 1979 and 1980, and to provide gestational data and information about the delivery of services. Questionnaires were sent to facilities that had reported abortions in either 1977 or 1978 as well as to other facilities thought to have provided abortions in 1979 or 1980. New providers were identified through newspaper articles from a national clipping service and through queries to persons knowledgeable about local abortion services, such as state coordinators of the National Abortion Rights Action League and Planned Parenthood affiliates.

Two follow-up mailings were sent to facilities that did not respond to the original one. If no response was received, state health department data were used where available; if they were not available, attempts were made to elicit the information through telephone calls. In a few instances, when these efforts were unsuccessful, estimates were obtained from knowledgeable persons in the community. By means of these procedures, information was obtained for 94 percent of the potential respondents. The most extensive follow-up efforts were concentrated on the larger providers; nonrespondents are believed to have provided few abortions in the study years.*

The number of abortions reported to the AGI is typically higher than the number reported to the Centers for Disease Control (CDC),[1] the other source of national data on abortion. The reason is that the AGI surveys providers directly, while the CDC data for most states are based on summary information reported by state health departments, which may not receive information from all

Figure 1. Rates of legal abortion per 1,000 women aged 15–44, various countries, 1980



*1979. †Residents only. ‡1978.

Sources: C. Tietze, *Induced Abortion: A World Review*, The Population Council, New York, 1981; and data collected by C. Tietze from various sources.

*For a more detailed explanation of the survey methodology, see reference 2 and citation in biographical footnote on page 5.

providers. Discrepancies between the resulting national estimates are due to differences in the methods of data collection.*

Although the AGI surveys undoubtedly include almost all sizable abortion providers, there are probably some smaller providers that have not been identified. Supplementary sample surveys of obstetrician-gynecologists and of hospitals have been conducted to estimate the degree of error.[2] Data from both these surveys suggest that the actual number of abortions performed may in fact be three to six percent higher than the number reported to the AGI. The numbers and analyses presented here are based on the reported number of abortions; data are not adjusted for the possible undercount.

Findings

As panel 1 of Table 1 shows, there were 1,497,700 legal abortions in 1979 and 1,553,900 in 1980. About three percent of the 33 million women aged 15–44 (29.4 per 1,000, as seen in panel 3†) obtained legal abortions in 1980. As in previous years, the vast majority of abortions (96 percent) were concentrated in metropolitan areas. The overall number of providers (panel 2) and the number in metropolitan areas rose slightly in 1980, but the number in nonmetropolitan areas declined somewhat. The ratio was 300 abortions per 1,000 pregnancies ending in live births or abortions (panel 4). When miscarriages and stillbirths are taken into account, the proportion of pregnancies ending in abortion is about one-fourth.

The number of legal abortions reflects the number of unintended pregnancies experienced by American women. In 1978 (the latest year for which estimates have been made), there were more than three million unintended pregnancies; this figure represents 55 percent of the 5.6 million pregnancies that occurred that year. Just under half of these unintended pregnancies were terminated by abortion; the remainder resulted in births or miscarriages.[3] Thus, the abortion rate is much lower than it would be if many women did not carry unintended pregnancies to term, either by choice or because they were unable to obtain abortion services.

As Figure 1 shows, the abortion rate is higher in the United States than in the Western European countries for which accurate data are available and is lower in the United States than in Eastern European countries and Cuba. Rates are estimated to be even higher in Japan and the Soviet Union (not shown).

As shown below, the rate of increase in abortions has been declining steadily and appears to be leveling off. There was a four percent increase between 1978 and 1979, and a two percent increase between 1979 and 1980. If this trend continues, figures for 1981 or 1982 should show that the rate has stabilized.

Year	Abortion rate	% increase over previous year
1973	16.6	u
1974	19.6	18
1975	22.1	13
1976	24.5	11
1977	26.9	10
1978	28.2	5
1979	29.3	4
1980	30.0	2

Note: u=unavailable.

Much of the rise in the abortion rate and ratio in the first years after legalization, between 1973 and 1975, may be attributed to the rapid diffusion of abortion services (and of information regarding availability) to most large metropolitan areas during that period.

Since 1975, the most important factor in the abortion rate rise has probably been the increased rate of unintended pregnancy due to a widespread shift away from the use of the most effective methods of contraception. The proportion of all American women aged 15–44 using the pill is estimated to have fallen by as much as one-fourth between 1975 and 1978, and has probably declined further since.‡ Because most of the women who would previously have used oral contraceptives are undoubtedly using methods with higher use-failure rates or are using no method at all, the shift away from the pill could account for much of the increase in the national abortion rate. Other factors that may be contributing to the rising rate of unintended pregnancy—and, therefore, to the rising abortion rate—are a decrease in the use of the IUD[4] and an increase in the proportion of unmarried women who are sexually active.[5] Increased use of contraceptive sterilization,[6] on the other hand, is working to reduce the rate of unintended pregnancy. In addition, the abortion rate may be affected by changes in the proportion of women who choose to terminate unintended pregnancies by abortion, although there will be no measure of this until data from Cycle III of the National Survey of Family Growth become available.

If the U.S. abortion rate stabilizes at or near its present level, the implication is not necessarily that all women needing abortion services are able to obtain them, or that women who can obtain them are able to do so readily. There is abundant evidence that many women still find abortion services difficult or impossible to get because of the distance they live from the nearest provider, the cost, a lack of information on where and how to get an abortion and other restrictions. Plateauing of the abortion rate may, in fact, reflect a freezing of the abortion delivery system or an increase of restrictions on the provision of abortion. The data below describe the variations in abortion service availability across the United States, the diverse types of providers that represent a small subset of the medical system women generally use and the restrictions some women must contend with once they locate a provider.

Geographic Availability

Even after eight years of slow diffusion, abortion services are not uniformly available in all areas of the country. An indication of maldistribution of abortion services is the wide variation among states in the abortion occurrence rate (i.e., the number of abortions obtained in the state per 1,000 women aged 15–44 who live in the state). Although one would expect a degree of variation in abortion rates, as in birthrates, the observed range—from seven in West Virginia to 47 in Nevada—is very large, as Table 2 (page 8) shows.§ In some cases, neighboring states—Kansas and Nebraska, North Dakota and South Dakota, and New Hampshire and Vermont, for example—that are generally similar in other respects have markedly different abortion rates, apparently because of differing abortion service availability.

Past inadequacy of abortion services is reflected in the fact that states with the largest percentage increases in abortions between

*Not all states require reporting of abortions. In addition, in states that do have reporting systems, there are variations in the types of providers that must report, in the completeness of reporting by providers and in the follow-up by the health department.

†The 1980 census found about two percent more women of reproductive age than had been projected from earlier data. Therefore, the abortion rate based on the actual 1980 census count (29.4) is about two percent lower than that calculated using the number of women that had been projected (30.0). Since the rates for 1979 and earlier years were calculated using projected population estimates, the 1980 rate based on the projected population will be used for all comparisons with earlier years, although the rate based on the new census data is more accurate.

‡Pill use calculated from "OCs—Update on Usage, Safety, and Side Effects," *Population Reports*, Series A, No. 5, Jan. 1979, and AGI, *Data and Analyses for 1980 Revision of DHHS Five-Year Plan for Family Planning Services*, New York, 1981.

§Birthrates per 1,000 population in 1978 ranged from 11.9 in Massachusetts to 29.3 in Utah, a difference of a factor of 2.3, compared to a difference of a factor of 6.7 between the highest and lowest state abortion rates. (For birthrates, see: U.S. Bureau of the Census, *Statistical Abstract of the United States, 1980*, U.S. Government Printing Office, Washington, D.C., 1980.)

Table 2. Number of reported abortions by state of occurrence, 1978, 1979 and 1980; change 1978–1980; percentage change 1978–1980; and rate per 1,000 women aged 15–44, 1980

State	No. of abortions			Change 1978–1980	% change 1978–1980	Abortion occurrence rate, 1980*
	1978	1979	1980			
U.S. total	**1,409,600**	**1,497,670**	**1,553,890**	**144,290**	**10**	**29.4**
Ala.	15,120	17,590	20,780	5,660	37	23.2
Alaska	2,600	1,890	1,890	−710	−27	18.0
Ariz.	13,370	14,500	15,790	2,420	18	25.3
Ark.	5,150	6,110	6,190	1,040	20	12.3
Calif.	234,520	248,080	250,380	15,860	7	44.0
Colo.	19,800	22,420	23,140	3,340	17	31.6
Conn.	17,800	18,390	18,450	650	4	25.6
Del.	3,470	3,650	3,740	270	8	26.0
D.C.	30,850	28,670	28,520	−2,330	−8	167.8
Fla.	63,470	70,190	73,580	10,110	16	35.8
Ga.	36,080	38,760	37,890	1,810	5	28.6
Hawaii	7,090	7,600	7,960	870	12	34.6
Idaho	1,800	2,050	2,740	940	52	12.8
Ill.	70,280	70,920	69,110	−1,170	−2	26.0
Ind.	15,340	18,910	19,630	4,290	28	15.4
Iowa	7,530	9,280	9,280	1,750	23	14.3
Kans.	12,870	13,720	13,570	700	5	25.6
Ky.	12,470	12,860	12,820	350	3	15.2
La.	13,290	16,040	17,680	4,390	33	17.7
Maine	5,150	4,680	4,750	−400	−8	18.7
Md.	25,780	28,020	30,490	4,710	18	29.3
Mass.	42,610	45,110	45,590	2,980	7	33.6
Mich.	56,550	63,020	65,230	8,680	15	29.8
Minn.	17,580	19,080	19,920	2,340	13	20.8
Miss.	4,010	5,060	6,080	2,070	52	10.7
Mo.	15,570	17,740	21,620	6,050	39	19.4
Mont.	3,100	3,550	3,670	570	18	20.2
Nebr.	6,630	5,660	6,350	−280	−4	18.0
Nev.	6,060	8,200	9,170	3,110	51	47.2
N.H.	3,980	4,210	4,660	680	17	21.3
N.J.	48,040	51,230	55,460	7,420	15	32.9
N. Mex.	6,250	8,020	8,410	2,160	35	27.2
N.Y.	187,050	183,190	187,460	410	†	45.9
N.C.	30,120	30,370	31,890	1,770	6	22.9
N. Dak.	2,240	2,810	3,140	900	40	21.6
Ohio	57,140	64,380	67,140	10,000	18	26.8
Okla.	11,180	10,820	11,280	100	1	16.5
Oreg.	14,450	17,690	17,670	3,220	22	28.5
Pa.	65,150	64,920	68,910	3,760	6	26.1
R.I.	4,570	5,650	6,640	2,070	45	30.8
S.C.	13,050	13,170	13,660	610	5	18.3
S. Dak.	1,400	1,440	1,360	−40	−3	9.1
Tenn.	23,040	25,430	25,590	2,550	11	23.7
Tex.	83,280	94,080	102,000	18,720	22	30.2
Utah	3,150	3,810	4,200	1,050	33	12.4
Vt.	3,290	3,360	3,760	470	14	30.8
Va.	30,370	31,380	31,760	1,390	5	24.3
Wash.	34,490	35,580	37,030	2,540	7	37.7
W. Va.	2,840	3,100	3,000	160	6	7.0
Wis.	17,510	20,240	21,790	4,280	24	20.1
Wyo.	1,070	1,020	1,070	0	0	9.6

*Rate based on April 1, 1980, populations from U.S. Bureau of the Census, unpublished data from the 1980 census.
†Less than 0.5 percent.

1978 and 1980 tended to have low abortion rates in 1978. The number of abortions increased by at least one-third in 10 states—Alabama, Idaho, Louisiana, Mississippi, Missouri, Nevada, New Mexico, North Dakota, Rhode Island and Utah. The average abortion occurrence rate in 1978 in these states was 17.0, much lower than the average of 23.7 in all other states (not shown). In these 10 states, an average of 25 percent of women obtaining abortions traveled out of state for their procedures in 1978, compared to 15 percent of those who lived in the other 40 states.[7] In four of the 10 states (Alabama, Louisiana, Mississippi and Missouri), abortions occurring in clinics established since 1978 amounted to between 21 and 30 percent of the number that were performed in 1978, suggesting that the addition of new providers in these states enabled more women to terminate unintended pregnancies by abortion or to do so without traveling to other states. That the opening of a single abortion facility can influence a state's abortion occurrence rate, as happened in Mississippi, suggests that many women are unable to obtain the abortion services they want and need when these services are unavailable locally.*

The AGI has attempted to measure the availability of abortion services more directly by calculating the proportion of women of reproductive age living in counties without any abortion services. This measure is imperfect, since the existence of a single abortion facility in a woman's county of residence may not mean that the specific services she needs are available and accessible to her; conversely, many women in counties without a provider may have access to a facility in a neighboring county. Nevertheless, the absence of an abortion provider in a woman's home county suggests that abortion services are not readily available to her.

Evidence of the importance of having abortion services available locally may be found by relating the availability of abortion services in a state to the resident abortion rate (i.e., the number of abortions obtained in the state or elsewhere by state residents per 1,000 state residents).† In 1978, among the 50 states there was an extremely high correlation (0.81) between the proportion of women living in counties with any abortion services and the proportion of residents of

(Continued on page 10)

*For another study showing that abortion rates tend to rise when abortion services become available locally, see J. D. Shelton, E. A. Brann and K. F. Schulz, "Abortion Utilization: Does Travel Distance Matter?" *Family Planning Perspectives*, 8:280, 1976.

†A later article will present resident abortion rates for each state.

(Continued from page 8)

the state who obtained an abortion.* That is, abortions were much more likely to be obtained by residents of states where most women live in counties with abortion services than by residents of states where few women live in counties with services.

Although many of the women living in unserved areas apparently are unable to obtain abortions, some are able to travel to other cities, even great distances, for abortion services. However, the need to travel, especially when long distances are involved, presents substantial disadvantages for many women: Costs are increased because of travel expenses and the possible need for overnight lodging, rapid diagnosis and treatment of postabortion complications are more difficult, and privacy is jeopardized by the need to be away from home and work for a longer period of time. If, because of distance or any other factor, the abortion is delayed until a later point in gestation, the risk of morbidity and mortality increases,[8] and the cost of the procedure may increase as well. The problems caused by distance are particularly severe for low-income women and teenagers.

Results of the 1980 survey make clear that many women live in areas that still have no abortion services available. As Table 3 shows, 78 percent of all U.S. counties have no identified abortion service provider, and about 28 percent of all women of reproductive age live in these counties.

Calculations were also made of the proportion of women living in counties without at least one facility providing 400 or more abortions during 1980, since a provider of this size is more likely to be known and accessible to the average women than is a smaller facility. In 92 percent of counties, no facility reported 400 or more abortions; 44 percent of women live in these counties.

Furthermore, since 1976 the extension of abortion services to previously unserved areas has proceeded at a slow pace, after the substantial gains that were registered between 1973 and 1976, as the table shows. The proportion of women living in unserved counties has remained virtually unchanged since 1976; the proportion living in counties without a provider of 400 or more abortions has declined slightly. (As was shown in Table 1, a similar pattern is evident in the total number of identified abortion service providers, which increased by 58 percent from 1973 to 1976, but has increased by only seven percent since 1976.)

The problem of access to abortion services is particularly severe for nonmetropolitan women, since abortion facilities are concentrated in urban areas. Almost 70 percent of nonmetropolitan women live in counties with no facility reporting even one abortion, as Table 3 shows, and 95 percent live in counties without a provider reporting 400 or more abortions. Put another way, only 4.5 percent of abortions take place in nonmetropolitan areas, although about 26 percent of women of reproductive age live in these areas (not shown). The situation has changed little since 1974, when 4.2 percent of abortions were reported in nonmetropolitan areas. Since 1978, the number of nonmetropolitan abortion providers has declined slightly, while the number of providers in metropolitan areas has continued to increase slowly.

Even in metropolitan areas, however, 13 percent of women live in counties without an abortion facility, and 26 percent live in counties without any facility reporting 400 or more abortions. Fifty-nine of the 305 SMSAs have no identified abortion provider and an additional 25 SMSAs report fewer than 50 abortions. Table 4 lists these areas. Each SMSA would have more than 400 abortions if their abortion rates approached the national average.

Map 1 (page 13) shows the availability of abortion services in each state. In 15 states, fewer than half of all women of reproductive age live in counties with an identified abortion service provider. In four states—Mississippi, North Dakota, South Dakota and West Virginia—fewer than one-quarter of such women live in counties with any provider (not shown).

Table 3. Percentage of counties with no abortion facilities and percentage of women aged 15–44 living in counties with no abortion facilities, by metropolitan status,* 1973–1980

Measure	1973	1974	1975	1976	1977	1978	1979	1980
Counties (N=3,105)								
% with no facility	83.3	80.5	78.6	77.3	76.9	77.0	77.9	77.7
Metro	56.6	51.8	49.1	47.5	46.6	46.6	46.7	46.9
Nonmetro	90.3	88.1	86.3	85.0	84.8	84.9	86.0	85.8
% without at least one facility reporting ≥400 abortions during the year	96.2	94.8	94.0	93.5	92.7	92.7	92.4	92.2
Metro	82.7	77.0	74.7	72.2	68.9	68.9	67.7	67.2
Nonmetro	99.8	99.4	99.1	99.0	98.9	98.8	98.8	98.7
Women aged 15–44† (N=50,029,000)								
% living in a county with no facility	35.0	31.3	29.2	28.0	27.6	27.7	27.9	27.9
Metro	20.0	16.2	14.8	13.9	13.3	13.4	13.1	13.3
Nonmetro	77.5	74.2	70.1	67.9	68.3	68.3	69.6	69.4
% living in a county without at least one facility reporting ≥400 abortions during the year	59.4	53.6	51.1	48.5	45.7	45.4	44.1	43.8
Metro	45.4	37.9	35.0	31.5	28.0	27.6	26.0	25.8
Nonmetro	99.0	98.0	96.6	96.5	96.0	95.9	95.5	95.0

*Data for metropolitan areas are presented for SMSAs and New England County Metropolitan Areas as defined by criteria published by the Office of Management and Budget, Oct. 1975.

†Based on 1978 population estimates.

Where Women Go for Abortion Services

While a large number of facilities—2,758—report providing abortion services, only a small fraction of these represent meaningful access to abortion services for more than a few women. The majority of abortions occur in a relatively small number of large facilities, as Table 5 (page 12) makes clear. Seventy-six percent of abortions are performed in the 439 nonhospital clinics and hospitals that serve 1,000 or more abortion patients during the year; 18 percent occur in the 38 facilities that perform 5,000 or more abortions. In many instances, the large facilities are especially effective in providing access because of their relatively low fees[9] and their visibility, due both to their size and to the fact that many of them advertise their existence and the services they offer. On the other hand, small providers also may play an important role in providing access to services in areas without other abortion facilities.

• ***Hospitals.*** The AGI survey identified 1,504 hospitals reporting abortions in 1980, which constitute 55 percent of all abortion providers. The average caseload of the hospitals is small, however, and only 22 percent of all abortions take place in hospitals. About one-third of the hospitals report fewer than

*Adjusted for state differences in the age and race distributions of women aged 15–44, since these factors are highly related to abortion utilization.

30 abortions each. Some report only one or two abortions, indicating that abortions are performed only in special situations and are not generally available.

Although many poor women rely on public hospitals as their primary source of health care, public hospitals are less likely than private hospitals to provide abortions, as Table 6 (page 12) shows. Only 17 percent of public hospitals, compared with 34 percent of private general hospitals, report any abortions. These differentials are evident in metropolitan and nonmetropolitan areas.

Table 7 (page 12) provides a more detailed breakdown of the types of public and private hospitals and nonhospital facilities providing abortion services.

Over time, abortion services have become slightly less available in hospitals. The proportion of short-term general non-Catholic hospitals reporting abortion services has fallen by four percentage points since 1976 (not shown). Between 1978 and 1980, while the number of nonhospital facilities has increased, the number of hospitals reporting abortions has fallen by 122, or eight percent. Among public hospitals, there has been a sharp drop in the number of military facilities reporting abortions because of restrictions imposed by federal legislation,* [10] but among other types of public hospitals the drop was only two percent (not shown). Among the private hospitals, the drop was eight percent for the voluntary (nonprofit) non–church-affiliated hospitals and six percent among the proprietary (for profit) hospitals. Abortion services declined among both proprietary and nonmilitary public hospitals. Since proprietary hospitals are believed to be less affected by public opinion than public facilities, it may be inferred that the decline in services among nonmilitary public hospitals resulted from factors affecting all types of hospitals rather than simply pressure exerted by antiabortion groups.

In fact, each year since abortion was legalized, a decreasing proportion of abortions have taken place in hospitals. As Table 8 (page 13) shows, in 1973, 52 percent of all abortions were performed in hospitals, but by 1980 the proportion had fallen to 22 percent. The actual number of abortions occurring in hospitals also dropped between 1973 and 1980, by 17 percent in public hospitals and by 10 percent in private hospitals. The table also shows the striking concomitant increase in the number of abortions performed in nonhospital facilities.

*The annual appropriations bill for the Department of Defense for FY 1979 contained a rider severely restricting the abortion coverage of CHAMPUS, the health insurance plan for military dependents and retirees.

A number of factors have encouraged the shift from hospitals to nonhospital facilities. By 1973, there had been relatively little experience with abortion, and much of the medical profession assumed that the procedure would be safest if performed in a hospital setting. As experience increased, and as vacuum aspiration replaced sharp curettage as the predominant procedure, it became evident that first-trimester abortion, when performed as an ambulatory procedure in a properly equipped nonhospital clinic or doctor's office, is at least as safe as when performed in a hospital.[11] (Other types of minor surgery are also being performed increasingly in doctors' offices and nonhospital surgicenters.) The development of the dilatation and evacuation procedure has extended to at least 16 weeks the gestation at which abortions can be performed safely in clinics.[12] Given the safety of outpatient abortions, the cost advantage of clinics became an important factor encouraging women to turn to clinics for abortion services.[13] Hospital abortions usually involve both physician fees and charges for use of the hospital facilities, and in many cases patients must pay for one or two days of hospitalization. Additional advantages of specialized high-volume abortion facilities are the expertise that results from the staff's performing a procedure many times; the attitudes and skills of the personnel, who, unlike the usual hospital staff, are selected and trained to serve abortion patients; and the availability of trained abortion counselors. While some hospitals have developed outpatient abortion clinics that have the advantages of freestanding clinics, most do not appear to be interested in developing such a facility, in part because of the public relations problems that might result.

• *Nonhospital facilities.* Most of the large abortion providers are nonhospital clinics. As noted above, 38 facilities perform 5,000 or more abortions; 34 are nonhospital clinics and four are hospitals. Similarly, 345 of the 421 facilities that report 1,000 to 4,999 abortions are nonhospital facilities.

The availability of nonhospital abortion services has increased somewhat since 1978. As was shown in Table 7, the total number of nonhospital facilities providing abortions has grown by 11 percent since 1978. Perhaps more important to women seeking abortions, the number of clinics serving 400 or more abortion patients has grown by 18 percent, and the number of physicians' offices reporting this many abortions has risen by 22 percent. Although many new large facilities are located in areas with existing providers, or were small facilities whose caseloads have increased, others have opened in previously unserved areas and represent a continuing

Table 4. SMSAs reporting fewer than 50 abortions, by state, 1980

State and SMSA	State and SMSA
Alabama	**North Dakota**
Anniston*	Bismarck
Florence*	Fargo
Gadsden	
	Ohio
Arkansas	Canton*
Fayetteville*	Hamilton*
Ft. Smith*	Lima
Texarkana*	Lorain
	Mansfield
California	Newark
Visalia*	Springfield
	Steubenville
Colorado	
Pueblo*	**Oklahoma**
	Enid
Florida	Lawton
Bradenton*	
Ft. Walton Beach*	**Pennsylvania**
Panama City*	Altoona*
	Erie
Georgia	Johnstown*
Athens*	Lancaster
	Sharon*
Illinois	State College
Bloomington	
Decatur	**South Carolina**
Kankakee	Anderson
Springfield	Florence
	Rock Hill
Indiana	
Anderson	**South Dakota**
Elkhart	Sioux Falls
Kokomo	
Lafayette	**Tennessee**
Muncie	Clarksville
Terre Haute	
	Texas
Iowa	Abilene*
Dubuque	Amarillo*
	Bryan
Kentucky	Galveston*
Owensboro	Laredo
	Longview
Louisiana	Midland
Alexandria	San Angelo
Lafayette	Sherman
Lake Charles	Tyler
Monroe	Victoria
	Waco
Maine	
Lewiston*	**Utah**
	Provo
Michigan	
Battle Creek*	**Virginia**
Bay City*	Danville
Minnesota	**Washington**
St. Cloud	Bremerton
	Richland
Mississippi	
Pascagoula	**West Virginia**
	Huntington
Missouri	Parkersburg
Joplin	
St. Joseph	**Wisconsin**
	Appleton*
New Jersey	Janesville
Vineland	Kenosha
	LaCrosse*
New Mexico	Sheboygan
Las Cruces*	Wausau

*Reported between one and 50 abortions in 1980. SMSAs without an asterisk did not report any abortions in 1980.

Table 5. Number and percentage distribution of abortion service facilities and abortions, by type of facility, according to caseload, 1980

Caseload*	Facilities						Abortions					
	Total		Hospital		Nonhospital		Total		Hospital		Nonhospital	
	N	%	N	% of total	N	% of total	N	%	N	% of total	N	% of total
Total	**2,758**	**100**	**1,504**	**55**	**1,254**	**45**	**1,553,890**	**100**	**341,030**	**22**	**1,212,860**	**78**
<30	650	24	520	19	130	5	6,880	†	5,210	†	1,670	†
30–399	1,352	49	788	29	564	20	179,280	12	95,540	6	83,740	5
400–999	297	11	116	4	181	7	189,090	12	68,440	5	120,650	8
1,000–4,999	421	15	76	3	345	12	905,910	58	142,240	9	763,670	49
≥5,000	38	1	4	†	34	1	272,730	18	29,600	2	243,130	16

*In this and subsequent tables, caseloads are rounded to nearest 10. †Less than one percent.

Table 6. Percentage of short-term general non-Catholic hospitals providing abortions, by metropolitan status, according to hospital type, 1980 (number of hospitals in each cell shown in parentheses*)

Metropolitan status	Hospital type					
	Total		Public		Private	
U.S. total	**27**	**(5,538)**	**17**	**(2,118)**	**34**	**(3,420)**
Metro	42	(2,700)	32	(680)	45	(2,020)
Nonmetro	13	(2,838)	10	(1,438)	16	(1,400)

*Numbers of hospitals are based on a special tabulation of the 1978 American Hospital Association (AHA) hospital survey. From 1978 to 1980, the number of public hospitals declined by 0.1 percent and the number of private hospitals declined by 0.5 percent. (See: AHA, *American Hospital Association Guide to the Health Care Field, 1981 Edition*, Chicago, 1981, Table 1.)

slow diffusion of abortion services to an ever larger proportion of the population.

Many of the clinics offering abortion services cannot be characterized accurately as abortion clinics. Twenty percent of those responding to the AGI survey describe their facilities as general ob-gyn practices that include abortion among other services provided, four percent offer general fertility-related services and six percent say they provide general medical care (see Table 9, page 14). Another four percent, classified as "other," are mainly surgical practices or multispecialty groups. While nonabortion services are more commonly offered by the clinics providing smaller numbers of abortions, 18 percent of even the largest abortion providers, those reporting 1,000 or more abortions, describe their primary services as other than abortion. Although it may be easier for women seeking abortions to find out about specialized abortion clinics, the existence of abortion services in a variety of types of clinics in a single metropolitan area undoubtedly facilitates their access to abortion services.

Among the physicians providing fewer than 400 abortions in their offices, almost all—87 percent—are described as having ob-gyn practices (not shown). Only six percent have general medical practices. However, general practitioners performing abortions may be less well covered by the AGI survey than are obstetrician-gynecologists.

The AGI survey identified 723 physicians' practices where office abortions are performed; this number represents only a small proportion of the 18,000 obstetrician-gynecologists in private practice in the United States.[14] The questionnaire that went to private medical practices asked how many physicians in the practice provide abortions. Most practices (63 percent) report that only one physician performs abortions, although the numbers range as high as eight or more. Thus, assuming that the numbers of physicians per practice are similar among respondents and nonrespondents, it can be estimated that the number of physicians reporting abortions in their offices is 1,200. This estimate is a minimum figure, since it is known that the survey misses some physicians who perform small numbers of abortions in their offices. Allowing for a possible undercount, about one in 10 obstetrician-gynecologists in private practice perform abortions in their offices. Thus, relatively few women are able to obtain abortion services in the offices of their private gynecologists or obstetricians.

Restrictions on Services

Even a woman who lives in an area with an abortion provider may not be able to obtain the abortion services she needs locally. There are a number of restrictions on services that preclude many women from utilizing a particular facility or even any facility in an area or state. Some of these restrictions result from legislation or from provider policies intended to limit the number of abortions; others represent limitations of the resources and capabilities of providers. Among the restrictions are parental notification and consent requirements for minors, Medicaid funding limitations, lack of outpatient abortion services in many hospitals where abortions are performed, the policy of some providers not to accept new patients seeking abortions and limitation of abortion to early gestational ages.

• ***Parental notification and consent.*** Parental notification and parental consent requirements can pose a significant obstacle for minors seeking abortion services. These requirements have been imposed both by individual abortion providers and by state and local legislation, although the constitutionality of such legislation is being challenged. According to a survey of abortion providers conducted by the AGI,[15] 38 percent of hospitals and 19 percent of clinics have parental consent or notification requirements for minors under age 18; and 48 and 38 percent of hospitals and clinics, respectively, have such requirements for those under 15. It is estimated that 37 percent of teenagers under 18 who obtained legal abortions in 1978 did so in hospitals and clinics with parental consent or notification requirements.

In Maryland, Montana and Utah, laws are in effect that require parental notification;

Table 7. Number of facilities providing abortion services, by type of facility, 1978, 1979 and 1980, and change 1978–1980

Facility	1978	1979	1980	Change 1978–1980	
				N	%
All facilities	**2,753**	**2,734**	**2,758**	**5**	*****
HOSPITALS					
Total	**1,626**	**1,526**	**1,504**	**−122**	**−8**
Public	**390**	**363**	**357**	**−33**	**−8**
Military	35	9	8	−27	−77
Other federal	3	3	3	0	0
State	43	41	41	−2	−5
Hospital district	126	136	136	10	8
County	113	105	102	−11	−10
City; city/county	70	69	67	−3	−4
Private	**1,236**	**1,163**	**1,147**	**−89**	**−7**
Voluntary, church	72	75	70	−2	3
Voluntary, other	919	858	846	−73	−8
Proprietary	245	230	231	−14	−6
NONHOSPITAL FACILITIES					
Total	**1,127**	**1,208**	**1,254**	**127**	**11**
Clinics	**470**	**511**	**531**	**61**	**13**
Caseload <400	105	111	102	−3	−3
Caseload ≥400	365	400	429	64	18
MDs' offices	**657**	**697**	**723**	**66**	**10**
Caseload <400	550	573	592	42	8
Caseload ≥400	107	124	131	24	22

*Less than one percent.

and Louisiana, Massachusetts, Minnesota and North Dakota require parental notification or consent, with the provision that a minor may seek the authorization of a judge as an alternative to parental involvement. Court authorization is granted if the judge determines that the teenager is mature enough to make an informed decision or, if she is not, that the abortion would be in her best interest. Although in Massachusetts almost all minors who seek court permission are granted it, the procedure subjects them to stress and anxiety, and may inhibit some from seeking abortion services.[16]

To assess the probable impact of parental notification and consent requirements, the AGI study referred to earlier[17] also surveyed minors obtaining abortions in a national sample of abortion clinics. Fifty-five percent of respondents said that one or both parents knew about their abortions, but 23 percent said that they would avoid having a legal abortion if their parents had to be told. (They were not asked about the option of obtaining court approval of the abortion without parental knowledge.) Of those who said that they would not have a legal abortion, 39 percent said they would have a self-induced or illegal abortion; 39 percent said that they would continue their pregnancies, nine percent, that they would leave home; 13 percent did not know what they would do.

A similar study found that three-quarters of a sample of 163 Minnesota teenagers under age 18 who were obtaining abortions had not told one or both parents about their abortions and therefore would be affected by a law requiring the consent of both parents.[18] Furthermore, 40 percent thought they could not get the consent of both parents and 42 percent said they would not get a legal abortion if parental notification were required. Those who would not seek a legal abortion under parental notification requirements said they would go to another state for an abortion (44 percent), continue the pregnancy (29 percent), leave home (16 percent) or seek an illegal abortion (11 percent).

● ***Medicaid funding restrictions.*** For poor women, the cost of an abortion may be a serious impediment to the utilization of abortion services. Until late in 1977, when the Hyde Amendment severely limited federal participation in Medicaid funding of abortions, Medicaid paid for abortions for significant numbers of poor women in many states. Since 1977, the number of Medicaid-funded abortions has been reduced as a consequence of the Hyde Amendment and of the policy of most states to adopt similar restrictions. The number of Medicaid abortions fell from 295,000 in FY 1977 to 194,000 in FY 1978 and 209,000 in FY 1979.[19] The number would have fallen more had a few of the states serving large numbers of Medicaid patients—notably California and New York—not continued to pay for Medicaid abortions. In addition, many of the states that adopted the restrictions had, in fact, been paying for abortions for only a fraction of the Medicaid-eligible women estimated to be in need of abortion services.*

As a result of the cutbacks in public funding of abortion, many poor women have found access to abortion services more difficult or impossible. The most extensive study of the importance of Medicaid funding found that between 18 and 23 percent of Medicaid-eligible women who would have obtained abortions when Medicaid funding was available instead carried their pregnancies to term when that funding was cut off.[20]

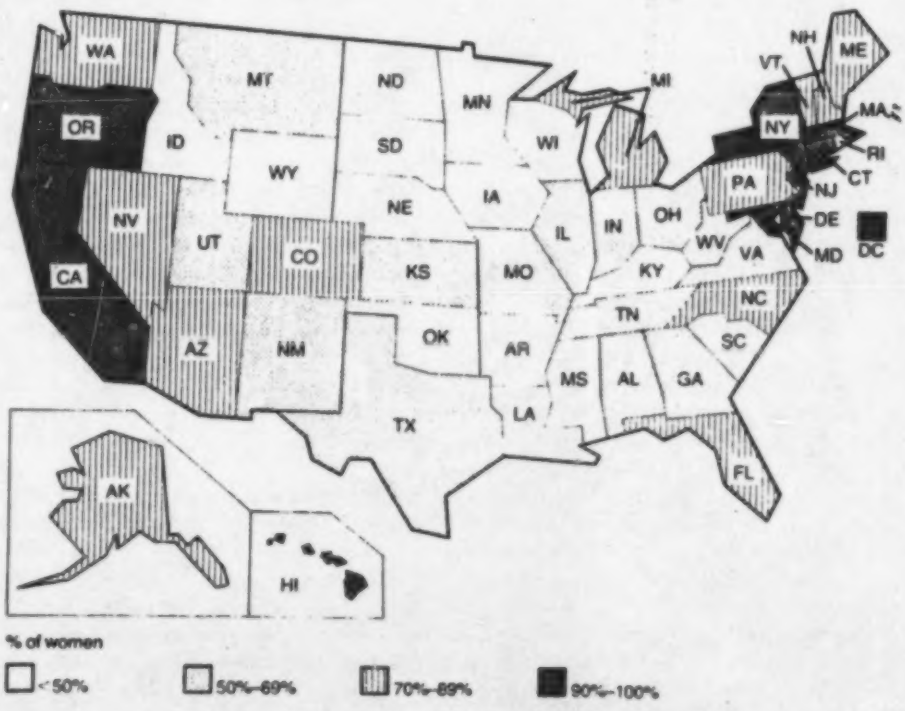
As of December 1981, 14 states and the District of Columbia were continuing to fund medically necessary abortions under Medicaid, even though federal funds for most of these abortions are no longer available. It is the policy of nine states—Alaska, Colorado, Hawaii, Maryland, Michigan, New York, North Carolina, Oregon and Washington—

Table 8. Number and percentage distribution of reported abortions, by type of facility,* 1973, 1978, 1979 and 1980

Type of facility	No. of abortions				% distribution			
	1973	1978	1979	1980	1973	1978	1979	1980
U.S. total	**744,600**	**1,409,600**	**1,497,670**	**1,553,890**	**100**	**100**	**100**	**100**
Hospitals	**385,920**	**350,520**	**347,970**	**341,030**	**52**	**25**	**23**	**22**
Public	83,110	76,430	73,150	68,660	11	5	5	4
Private	302,810	274,090	274,820	272,370	41	20	18	18
Nonhospital facilities	**358,680**	**1,059,080**	**1,149,700**	**1,212,860**	**48**	**75**	**77**	**78**
Clinics	343,470	998,850	1,086,920	1,145,090	46	71	73	74
Physicians' offices	15,210	60,230	62,780	67,770	2	4	4	4

*In this and subsequent tables, physicians' offices reporting 400 or more abortions a year are classified as clinics.

Map 1. Percentage of women aged 15–44 living in counties with abortion facilities, by state, 1980



*For details see: AGI, *Abortions and the Poor: Private Morality, Public Responsibility*, New York, 1979, p. 14.

Table 9. Percentage distribution of responding nonhospital clinics performing abortions, by types of services provided, according to caseload, 1980

Types of services provided	% of clinics, by caseload			
	Total	<400	400-990	≥1,000
	(N= 431)	(N= 73)	(N= 69)	(N= 289)
Primarily or exclusively abortions	66	14	53	82
General ob-gyn services	20	46	25	13
General fertility services	4	3	10	3
General medical care	6	23	9	1
Other	4	14	3	1

and of the District of Columbia to fund medically necessary abortions. California and Massachusetts are continuing to fund medically necessary abortions under final court order of their state supreme courts, which have held that such funding is required under the state constitution. Connecticut, New Jersey and Pennsylvania are under interim court order by state courts to fund abortions under Medicaid.[21]

Since Medicaid is a joint federal-state program, Medicaid-eligible women seeking health care such as abortion services must obtain those services in their home state. Their ability to travel across state lines to avoid restrictions such as parental notification or consent requirements or gestational age limitations is therefore curtailed, and they are affected by problems of service availability and accessibility to a greater extent than are higher income women.

• ***Hospital outpatient abortion services.*** Another factor affecting the cost of abortions is the dearth of outpatient abortion services in hospitals. In many hospitals, abortions are available only as costly inpatient procedures that involve payment usually for at least one day of hospitalization as well as operating room and physician charges. These fees, added to time lost from work or other responsibilities, represent a formidable financial obstacle for women with limited incomes.

Data available from 60 percent of hospitals (which reported 54 percent of all hospital abortions) indicate that only 33 percent of hospital abortion providers perform any outpatient abortions, and 33 percent of hospital abortions occur as outpatient procedures.

• ***Acceptance of self-referred patients.*** Because of the way U.S. hospitals are structured, most do not provide services directly to the public.* They simply permit their facilities to be used by attending physicians who provide medical care (sometimes including abortion services) to their own patients. This being the situation, even if a woman lives in an area with a hospital where abortions are performed, the chances are that she will not be able to arrange directly with the hospital to obtain an abortion. She will usually be told to seek this care from a private physician or, at most, will be referred to a specific physician who may be willing to perform an abortion in the hospital.

In the 1981 AGI survey, hospitals were asked whether they accept self-referred abortion patients for service. Of the hospital providers answering the question, only 26 percent responded in the affirmative, as Table 10 shows. The proportion is somewhat higher for public hospitals (34 percent) than for private hospitals (23 percent). Among providers performing 400 or more abortions a year, the majority (72 percent) accept self-referred patients; most of these presumably have organized abortion clinics. A large majority of hospital providers, however, have small caseloads (87 percent report fewer than 400 abortions in 1980), and only 19 percent of these accept self-referred patients. Often, then, a women cannot arrange directly with a hospital to obtain an abortion but must have as an intermediary an attending physician willing to accept her as a patient.

Table 10. Percentage of responding hospital abortion facilities that serve new self-referred patients, by caseload, according to hospital type, 1980 (number of hospitals in each cell shown in parentheses)

Caseload	Hospital type					
	Total		Public		Private	
Total	26	(861)	34	(205)	23	(656)
<400	19	(759)	26	(180)	17	(579)
≥400	72	(102)	88	(25)	66	(77)

Table 11. Percentage distribution of responding physicians' practices reporting office abortions, by type of referrals accepted, according to caseload, 1980

Type of referral	% of practices, by caseload			
	Total	<30	30-390	≥400
Accept referrals from other physicians or facilities	(N= 641)*	(N= 108)	(N= 415)	(N= 118)
Yes, routinely	93	81	95	98
Yes, under special circumstances	5	12	4	0
No	2	7	1	2
Accept new self-referred patients	(N= 636)	(N= 108)	(N= 412)	(N= 116)
Yes, routinely	91	80	93	96
Yes, under special circumstances	6	12	5	3
No	3	8	2	1
Total	100	100	100	100

*Number of practices responding to questionnaire.

Table 12. Percentage distribution of abortion facilities, by the maximum gestation at which the facility will provide abortions, according to type of facility, 1980

Maximum gestation (weeks LMP)	All facilities (N= 1,918)	Hospitals (N= 824)	Clinics (N= 565)	MDs' offices (N= 529)
5–6	3	3	*	7
7–8	12	11	2	22
9–10	15	15	9	23
11–12	37	34	43	35
13–14	12	5	27	9
15–16	4	4	8	1
17–20	11	18	8	3
≥21	6	10	3	*
Total	100	100	100	100

*Less than one percent.

• ***Limitations on gestation.*** If a woman does not discover her pregnancy early in gestation, or if she delays seeking an abortion, she will find that she is limited in the facilities willing to provide abortion services to her. Even within the first trimester of pregnancy, some providers restrict abortions to women whose pregnancy has lasted less than 10, eight, or even six weeks from the last menstrual period (LMP).

Respondents were asked, "What is generally the maximum gestation (in weeks since last menstrual period) of abortions provided in the hospital [in your facility, in your office]?" Since some responses were outside the expected range, a small sample of facilities were resurveyed to verify their answers. This check revealed that some respondents had reported weeks of conceptional age rather than weeks since LMP. In addition, some respondents, particularly those in the medical records departments of hospitals, had

*Some hospitals do have emergency rooms that respond directly to the public. And some have a variety of clinics, such as well-baby and prenatal clinics, that are open, in general, to publics within their own catchment area.

misunderstood the question or the facility's policy. However, the results are useful in that they reflect the general pattern of policies regarding gestation.

The responses suggest that many facilities restrict their services to early gestations. Fifty-two percent of the physicians and 29 percent of the hospitals ordinarily provide abortions only to women at 10 or fewer weeks' gestation (see Table 12). Some of the physicians apparently perform only menstrual regulation, which is included in the definition of abortion used by the AGI survey—seven percent of responding physicians report providing abortions only up to six weeks LMP. Relatively few physicians—about 13 percent—perform abortions in their offices past 12 weeks LMP. A very few physicians perform abortions in their offices past 16 weeks; some of these may initiate instillation abortions in their offices to be completed in a hospital.

Twenty-seven percent of the clinics say their cutoff point is 13 or 14 weeks. Most of these consider abortions at 14 weeks LMP to be first-trimester procedures, since this age equals 12 weeks postconception. Nineteen percent of clinics and 32 percent of hospitals perform abortions past 14 weeks LMP.

References

1. Centers for Disease Control, DHHS, *Abortion Surveillance, Annual Summary, 1978*, Atlanta, 1980.

2. S. K. Henshaw, J. D. Forrest, E. Sullivan and C. Tietze, *Abortion 1977–1979: Need & Services in the United States, Each State & Metropolitan Area*, The Alan Guttmacher Institute (AGI), 1981.

3. Ibid., p. 6.

4. AGI, *Data and Analyses for 1980 Revision of DHHS Five-Year Plan for Family Planning Services*, New York, 1981; and M. Zelnik and J. F. Kantner, "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan-Area Teenagers: 1971–1979, *Family Planning Perspectives*, 12:230, 1980.

5. M. Zelnik and J. F. Kantner, 1980, op. cit.

6. K. Ford, "Contraceptive Use in the United States, 1973–1976," *Family Planning Perspectives*, 10:264, 1978.

7. S. K. Henshaw et al., 1981, op. cit., p. 13.

8. W. Cates, Jr., K. F. Schulz, D. A. Grimes and C. W. Tyler, Jr., "The Effect of Delay and Method Choice on the Risk of Abortion Morbidity," *Family Planning Perspectives*, 9:266, 1977.

9. B. L. Lindheim, "Services, Policies and Costs in U.S. Abortion Facilities," *Family Planning Perspectives*, 11:283, 1979.

10. FY 1980 Department of Defense appropriations, Public Law 96-86.

11. D. A. Grimes, W. Cates, Jr., and C. W. Tyler, Jr., "Comparative Risk of Death from Legally Induced Abortion in Hospitals and Nonhospital Facilities," *Obstetrics and Gynecology*, 51:323, 1978.

12. D. A. Grimes, W. Cates, Jr., and R. M. Selik "Abortion Facilities and the Risk of Death," *Family Planning Perspectives*, 13:30, 1981.

13. B. L. Lindheim, 1979, op. cit.

14. American Medical Association, *Physician Distribution and Medical Licensure in the United States, 1979*, Chicago, 1980.

15. A. Torres, J. D. Forrest and S. Eisman, "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," *Family Planning Perspectives*, 12:284, 1980.

16. P. Donovan, "Your Parents or the Judge: Massachusetts' New Abortion Consent Law," *Family Planning Perspectives*, 13:224, 1981.

17. A. Torres et al., 1980, op. cit.

18. Affidavit of R. Anderson, submitted in Hodgson v. Minn. (U.S.D.C., Minn.), 1981.

19. S. K. Henshaw et al., 1981, op. cit., p. 63.

20. J. Trussell, J. Menken, B. L. Lindheim and B. Vaughan, "The Impact of Restricting Medicaid Financing for Abortion," *Family Planning Perspectives*, 12:120, 1980.

21. R. B. Gold, AGI, personal communication, Dec. 1981.

Document #3

Abortion: Need, Services and Policies

Virginia

This is one of 50 state reports on abortion need, services and policies in 1977.

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SUMMARY OF FINDINGS

- In 1977, there were an estimated 49,390 women in need of abortion services living in Virginia.

- Of these women, 30 percent were teenagers, 35 percent were 20-24 and 35 percent, 25 or older; 57 percent were white and 43 percent were nonwhite.

- There were 28,180 abortions reported in Virginia in 1977; 95 percent of these were obtained by Virginia residents and five percent were obtained by residents of other states.

- Most women obtaining abortions in Virginia were young (70 percent were under 25), unmarried, childless and in the first trimester of pregnancy at the time of abortion.

- Altogether, 35,300 Virginia residents obtained abortions in 1977 in the state or in another state. Thus, 71 percent of Virginia women in need of abortion services obtained them; 54 percent in the state and 17 percent in another state. Some of these women had to travel long distances to obtain abortion services.

- Forty-six percent of women in need were unable to obtain services in Virginia.

- The abortion rate in 1977 in Virginia was 23.0 abortions per 1,000 women of reproductive age (15-44).

- Approximately 5,600 Virginia women eligible for Medicaid-funded health care were in need of abortion services in FY 1977.

- During FY 1977, 4,000 abortions were funded by Medicaid in Virginia. About 1,600 Medicaid-eligible women who needed publicly funded abortion services did not obtain them. The rate of Medicaid-funded abortions in FY 1977 was 67.1 per 1,000 Medicaid-eligible women of reproductive age. For non-Medicaid-eligible women, the abortion rate was 25.1 per 1,000.

- Virginia is continuing, under court order, to fund abortion services for most Medicaid-eligible women.

- Provision of abortion services is heavily concentrated in the state's metropolitan areas. Some 81 percent of the women in need in nonmetropolitan counties lived in counties where there were no identified service providers; 17 percent of metropolitan women in need lived in counties with no services. The Washington SMSA, with 18 percent of the need, accounted for 22 percent of all abortions.

- The majority of the abortions in the state in 1977 (77 percent) were performed in 15 nonhospital clinics and physicians' offices; 24 percent occurred in hospitals.

- Abortion services were available in only 26 of the state's 95 hospitals: in four of the 14 public hospitals and in 22 of the 81 private hospitals.

- Virginia ranks low among the states in availability of abortion services. Only eighteen of the state's 98 counties had abortion providers reporting at least one abortion in 1977 or the first quarter of 1978. Of the 80 counties with no identified abortion services, 66 had at least 100 women in need in 1977; 12 of these had more than 400. In addition, there were 10 counties which had abortion service providers but in which fewer than half of the women in need were served.

- The rate of abortion in Virginia is lower than that in the United States as a whole. In 1977, Virginia was less successful in meeting abortion need than was generally the case in the country.

Area	Abortions per 1,000 women 15-44	Abortions per 1,000 births	Percent of abortion need met
United States	26.9	400.2	72
Virginia	23.0	400.4	57

- The characteristics of women obtaining abortions in the state differed slightly from those of comparable women in the United States as a whole. Virginia women were generally younger than most U. S. women obtaining abortions.

Area	Percent <20 years	Percent unmarried	Percent having first abortion
United States	31	76	77
Virginia	36	78	74*

* State information not available. Percentage shown is that of the other states of the South Atlantic census division.

Outpatient Saline Abortion

HAROLD SCHULMAN, MD, FACOG, IRWIN H. KAISER, MD, FACOG
and GEORGIA RANDOLPH, BS

In saline abortions performed in an ambulatory unit, morbidity was equal to or less than that reported for abortions administered on an inpatient basis. In the outpatient program, patients were given the option of aborting at home. Outpatient management provides a solution to the problem of the large number of teenagers and women in lower socioeconomic groups who do not seek abortion services until after 10 weeks' gestational age.

"In fact the practice of medicine has been aptly compared by Hippocrates to a combat and a farce played by three characters: the patient, the physician, and the disease . . ." *Rabelais*

THE DEVELOPMENT of an abortion service at a municipal hospital has already been described. One aspect of this program has been saline abortions performed upon ambulatory patients. This procedure was adopted for the following reasons:

1. A catheter technic, which seemed to eliminate the risks of serious acute hypernatremia, had been developed.

2. Extensive experience with intra-amniotic hypertonic saline instillation on an inpatient basis had permitted these observations:

Patients rarely had significant immediate symptoms, other than thirst, from the procedure.

Most patients aborted uneventfully.

Only about 20% of the patients received medication for pain; by the time most patients could persuade a nurse to get the medication, the patient was completing the abortion.

In the early years, doctors were summoned when patients aborted. Recognizing the safety of the spontaneous process, staff members began delaying their response and, eventually, instructed nurses about what to do. Soon nurses assumed complete responsibility, and the staff was called only when a problem was apparent. Those physicians who attempted to assist the patients seemed to add to the morbidity. Avulsion of fetal parts and incomplete separation of the placenta were noted to be results of well-intentioned intervention.

Patients confined to the ward awaiting abortion labor were often subjected to verbal and nonverbal condemnation by hospital personnel. When they went into labor, it was usually swift. These patients rarely received emotional or physical support.

In general, abortion occurred in 1–3 days. If it did not, psychologic pressures were placed upon the physician to accelerate the process, if the patient was in the hospital.

Outpatient management of saline abortion seems to have several advantages:

1. The patient is under observation initially, during the period of risk of hypernatremia. She may then be at home while awaiting the onset of abortion.

2. If she wishes, the patient can return to the hospital to complete the abortion, or she can remain in the privacy of her home. The safety of the spontaneous com-

From the Department of Gynecology and Obstetrics of Albert Einstein College of Medicine and the Bronx Municipal Hospital Center, Bronx, NY.

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pletion of abortion by this method can be a strong reassurance to the patient.

3. The patient is provided with a supply of analgesics, which she can take when she wishes, after adequate instruction. This plan is more likely to be effective than are requests made to a busy nurse in an hospital ward housing acutely ill patients.

4. Restraining the impulse of attendants to intervene in the process of abortion enhances safety.

5. The valuable time of the professional staff is conserved, and active patient care is restricted to the actual time of abortion.

6. The use of hospital beds in wards for acutely ill patients is limited to those with extraordinary problems.

Outpatient saline instillations were begun on Jan 22, 1970. An average of five patients per week were cared for until July 6 when the average increased to 30 per week. The change in the New York state abortion law and the consequent provision of supporting funds and personnel account for this increase. This report describes our experiences with the first 323 such patients, during the period from Jan 22, 1970 to Aug 31, 1970.

MATERIALS AND METHODS

The technic utilized has been uniform. The patient assumes the supine position, and the abdomen is exposed. No premedication is used. The abdomen is cleansed, and a point representing the middle of the fundus of the uterus is identified. The skin, fascia and peritoneum are then anesthesized with 1 or 2% lidocaine. The amniotic cavity is entered with a 14-gauge thin-walled needle, and the stylet is removed. If a free flow of amniotic fluid ensues, a No. 5F Teflon catheter is threaded through the needle several centimeters beyond its tip. This Teflon catheter is superior to polyethylene because it is flexible but incompressible, and its tip has these openings. The needle is then removed, and the rest of the procedure is carried out through the catheter.

An effort is then made to remove all of the fluid in the uterus. After this is done, a 20% NaCl solution is injected into the uterus. If fluid is not obtained easily, an exchange infusion is performed—saline is instilled and then an equal amount of fluid is removed. This process is repeated until the operator is certain that there is sufficient NaCl within the amniotic cavity. The maximum quantity injected should be 200 ml, which is 40 g of NaCl. A smaller volume is injected into smaller uteri when less fluid has been aspirated. Although the minimum quantity necessary to terminate all pregnancies has not been determined, we estimate that not less than 120 ml of 20% solution should be injected.

At the end of the procedure, one million units of aqueous penicillin is instilled. In addition to providing prophylaxis, this instillation clears the catheter of the salt solution which is caustic to the peritoneum. The patient should experience no discomfort during the procedure.

Symptoms of hypernatremia—headache, heat, thirst, numbness and tingling of the fingers—are an absolute indication for the operator to stop to re-evaluate the procedure. If the patient feels pain when saline is being injected, then the solution is being injected into tissue and, once again, the procedure must be interrupted and re-evaluated. The average time used for the entire process is 20 minutes.

If the patient feels well at the end of the procedure, she is observed for a short period of time and then sent home with the following instructions:

1. Drink at least two quarts of water that day.

2. Call the hospital in case of any fever, excessive bleeding or unusual symptoms.

3. Take medication (meperidine, 50 mg, a prescription for which she has been given)

when the cramps are strong and close together.

4. Call the hospital or come in to be checked if any tissue is passed at home. A 24-hour telephone service is provided.

5. Come back to the hospital if pain is severe.

Only in rare instances has the method been used earlier than Week 14 or later than Week 22 of gestation.

RESULTS

The ethnic origin age, marital status and parity of these 323 women are given in Table 1–4.

The duration of pregnancy at the time of saline instillation is listed in Table 5. We no longer do the procedure when the uterus is less than three fingerbreadths above the pubis. We were satisfied that it could be done earlier with a high degree of success by having an assistant push the fundus upward from the vagina. However, it is more time consuming, and the proximity of pubic hair may enhance the risk of infection.

TABLE 1. AGE DISTRIBUTION OF 323 WOMEN UNDERGOING OUT PATIENT ABORTION AFTER SALINE INSTILLATION

Age range (yr)	*No. of patients*
13–17	31
18–21	76
22–25	118
26–30	47
31–40	41
> 40	1
Not recorded	6

TABLE 2. ETHNIC DISTRIBUTION

Race	*No. of patients*
Negro	155
White	108
Puerto Rican	55
Not recorded	6

TABLE 3. MARITAL STATUS

Marital status	*No. of patients*
Married	102
Single	161
Separated	40
Divorced	8
Widowed	2
Not recorded	10

TABLE 4. PARITY

Parity	*No. of patients*
No previous pregnancy	134
1 child	68
2–4 children	105
> 4 children	13
Not recorded	3

TABLE 5. GESTATIONAL PERIOD DURING WHICH ABORTION WAS INDUCED BY SALINE INSTILLATION

Gestational period (wk)	*No. of patients*
< 14	18
14–16	132
17–19	118
20–22	49
> 22	2
Not recorded	2

To summarize our experiences with the first 323 patients: 53 patients were lost to followup, and, despite repeated efforts, we have been unable to locate them. This is disturbing, but many patients give false addresses and telephone numbers. Of the 323 patients, 211 aborted at home, on the way to the hospital or upon arrival; they did not require admission to the hospital. Surprisingly, we did not know what happened to 25 of the women in this group until they were called several days later. The reply was always the same: "Everything came out just as you said, and there was no bleeding or pain, so I didn't think there was any need to come in or call."

Eighteen patients developed fever (104°F or higher). In most patients, fever occurred at the time of abortion and responded rapidly to the usual antimicrobial drugs after the patient had aborted. In a few, this symptom developed several days after abortion.

Seventeen patients had a curettage for suspected incomplete passage of the placenta. Three patients required blood transfusion for excessive blood loss.

One patient did not abort spontaneously. The uterus was originally 16 weeks in size; 250 ml amniotic fluid were removed and 200 ml of hypertonic saline instilled. Coagulation studies were performed and remained within normal limits. The patient had an uneventful suction curettage of the uterus eight weeks later when the uterus had shrunken to 8 weeks' size.

In Table 6, the time from saline instillation to completion of abortion is listed. This data corresponds with that reported by others.

TABLE 6. PERIOD OF TIME ELAPSING BETWEEN SALINE INSTILLATION AND ABORTION

Time	*No. of patients*
< 24 hr	23
1–3 days	212
4–7 days	20
> 1 wk	13
Unknown to patient	2

The reasons for admission to the hospital are catalogued in Table 7. Most patients were in the process of aborting. Two were admitted after the procedure had been completed when the social circumstances at home were felt to be inadequate for the patient to assist in her own care.

TABLE 7. REASONS FOR ADMITTING THOSE WITH OUTPATIENT ABORTIONS TO THE HOSPITAL

Reason	*No. of patients*
Fever (100.4 or >)	18(6.7%)
Curettage	17
Transfusion	3
Late infection	2
In process of aborting	42
Leiomyoma	1
Social	2
Hysteria	1

When patients did not abort in one week, we have chosen not to repeat instillation. In our experience, when the procedure had been performed properly, the pregnancy was terminated. Without the patient in the hospital, the psychologic pressure to do something further to initiate labor is removed. Potential hazards of a second instillation are difficulty in entering the amniotic sac, hemorrhage or infection. In the 13 patients in whom abortion did not occur within one week, gestational age ranged from 12 to 18 weeks.

We have come under pressure to "do something" for the unusual patients who have not fallen into labor many days after saline instillation. Understandably, some of these patients feel uncertain about the success of the abortion. We have resisted this pressure because we believe that fetal death fulfills the essential obligation we have undertaken, and because no real medical risk is involved in awaiting spontaneous evacuation of the products of conception. We are impressed with the accidents, reported by others, resulting from surgical intervention or oxytocin administration after saline instillation. Clearly, the patients may need strong reassurance and psychologic support during this period.

Some unusual incidents occurred during the study. On one occasion, normal saline rather than 20% saline was instilled into eight patients. None of these women aborted, and, in no case, did the fetus die. After a hypertonic solution was instilled, all patients aborted within 24 hours.

One patient aborted within two days, and was thought incorrectly to have completed passage of the products. She continued to have a serosanguinous discharge, and uneventfully passed a small fibrotic placenta eight weeks later. We believe that the retained placenta is best managed expectantly unless fever or bleeding ensues.

Another patient had an amniocentesis performed at 16 weeks' gestation, and the fluid was found to be muddy colored. An intrauterine death was assumed to have occurred, and only 100 ml of hypertonic solution were instilled after 10 ml were removed. When the patient returned two weeks later, a fetal heart tone was detect-

able by Doptone. Repeat amniocentesis was performed, producing clear fluid with a few flecks of meconium floating in it; 200 ml of hypertonic saline were injected and the patient aborted without event. Clearly, the fetus can pass meconium as early as the sixteenth week; this does not necessarily mean that fetal death has occurred.

DISCUSSION

The safety of saline abortion continues to be debated in this country. During the past two years, three reviews have appeared in this Journal which have summarized the world's experience using hypertonic solutions to terminate pregnancy.[2-4] All reported deaths appear to be explainable on the basis of four errors in judgment:

1. Hypertonic glucose was used, associated with *Clostridium welchii* sepsis.[5,6]
2. Excessive concentrations or excessive quantities of NaCl were instilled.[3,7,8]
3. The procedure was done under general anesthesia, and the patient was unable to report symptoms of acute hypernatremia.[9]
4. A needle technic was used, and (or the technic was not described) intravascular or intraperitoneal injection could occur readily.[2,8,10,11]

The large clinical studies of Wagner and Fuchs, Goodlin and others plus our own inpatient experience with approximately 100 women led us to believe that saline abortion could be carried out safely with proper precautions.[2,12-15]

A certain morbidity can be expected: fever in 5–8% of the patients, incomplete separation of the placenta which may lead to curettage in about 8% of patients, and blood transfusion for excessive bleeding at the time of placental separation in 1–2%.

The most feared complication is hypernatremia. In general, the patient will develop symptoms at the time the procedure is being performed. Theoretically, the use of the catheter should prevent massive intravascular or intramyometrial injection. However, even when a catheter was being used, one patient developed a classical picture in the middle of the procedure. The physician assumed that the symptoms were due to an upper respiratory infection and nervousness. Serum sodium was 159 mEq/liter, and the patient became asymptomatic after receiving only 300 ml of 5% dextrose in water. She was given a total of two liters of the latter solution within three hours, and she was discharged after an adequate volume of urine was again being produced. An additional precaution against intravascular absorption is to avoid overdistention of the uterus.

When we began this program, patients were not offered the option of aborting at home. However, our inpatient experiences proved that many women aborted very rapidly after the onset of symptoms, and some aborted with minimal warning signs. Therefore, patients were informed of this possibility and were instructed about what to do if they did abort at home. To our surprise, many women elected to stay at home after gaining this information. Interestingly, this response occurred predominantly in patients in a lower socioeconomic group. On the basis of this experience, we now give a detailed description and precise instructions on a tape recorder to each patient as well as the choice of aborting at home or returning to the hospital. About 70% continue to chose to remain at home.

Not unexpectedly, this program has been a focus of much controversy. Many health professionals have suggested that it is more distressing psychologically to abort at home in one's own bed than in a hospital bed. We are not aware of any evidence to support such a presumption, and the large number of patients who chose to abort at home would seem to refute this proposition. Others have suggested that the patient should be in the hospital where she can be shielded from seeing and handling the fetus and placenta. We suggest that this may be another

manifestation of our traditional ways of delivering medical care, namely, to make the patient extremely dependent upon and eternally grateful to her doctors and nurses. Professionally and medically, the need for doctors or other professionals to perform the abortion for the patient does not appear to exist. Once having made the difficult decision to undergo abortion, the women is quite willing, if our experience is indicative, to assume reasonable responsibility for her own care.

We are disappointed that 16% of our patients have been lost to followup. Most of the patients who did not report and were contacted appear to have aborted uneventfully. Some may have gone to other hospital emergency rooms. If their problems were serious, we have not been notified. Repeatedly, we inform and caution our patients of the necessity to maintain contact with us, but the complexity of this social-medical entity leads to continued secretive behavior by this group of women.

Our present, past and continuing experience would support the current approach. The saline instillation is performed in an office or treatment room environment. The patient is sent home after the procedure is completed and after she has been observed for a short period of time. A small recovery-type room should be available for patients returning to abort. Ideally, this room should be near a treatment room where partially separated placentas can be removed. The recovery room should also have a telephone so that a woman can call whenever she has questions. Our unit is staffed by a nurse during the day-time hours and by junior and senior medical students at night. Since we have decided to do saline instillations only on Monday, Tuesday and Wednesday, the inpatient unit can be closed on Saturday and Sunday.

Department of Gynecology and Obstetrics
Albert Einstein College of Medicine of
Yeshiva University
Bronx, NY 10461

REFERENCES

1. Schulman H: Induced abortion in a municipal hospital. Obstet Gynec 36:616, 1970
2. Goodlin RC, McLennan CE, Choyce JM, et al: Therapeutic abortion with hypertonic intra-amniotic saline. Obstet Gynec 34:1, 1969
3. Kerenji TD: Hypernatremia following intrauterine instillation of hypertonic saline solution. Obstet Gynec 33:520, 1969
4. Schiffer MA: Induction of labor by intra-amniotic solution for therapeutic abortion or intrauterine death. Obstet Gynec 33:729, 1969
5. Briggs DW: Induction of labour with hypertonic glucose. Brit Med J 1:701, 1964
6. MacDonald D, O'Driscoll MK, Geoghegan FJ: Intra-amniotic dextrose—a maternal death. J Obstet Gynaec Brit Comm 72:452, 1965
7. Siiprija V, Siiprija S, Benyajati C: Hypernatremia complicating induction of labor. Obstet Gynec 26:799, 1965
8. Wagatsuma T: Intra-amniotic injection of saline for therapeutic abortion. Amer J Obstet Gynec 93:743, 1965
9. Cameron JM, Dayan AD: Association of brain damage with therapeutic abortion induced by amniotic fluid replacement: Report of two cases. Brit Med J 1:1010, 1966
10. Fisner GM, Piver JS: Acute renal failure after therapeutic abortion by intra-amniotic saline administration. New Eng J Med 279:360, 1968
11. Frost ACG: Death following intrauterine injection of hypertonic saline solution with hydatidiform mole. Amer J Obstet Gynec 101:342, 1968
12. DeWatteville H: Therapeutic interruption of pregnancy by intra-amniotic injection of 10% saline solution. Proc Roy Soc Med 62:828, 1969
13. Fuchs F: Advances in Obstetrics and Gynecology. First Edition. Edited by SL Marcus, CC Marcus. Baltimore, Williams and Wilkins Co, 1967, pp 258 270
14. Jaffin H, Kerenyi T, Wood EC: Termination of missed abortion and the induction of labor in midtrimester pregnancy. Amer J Obstet Gynec 84:602, 1962
15. Wagner G: Induction of abortion or labor by intraamniotic injection of hypertonic solutions. Clin Obstet Gynec 9:520, 1966
16. Johnson JWC, Cushner IM, Stevens NL: Hazards of using hypertonic saline for therapeutic abortion. Amer J Obstet Gynec 94:225, 1966
17. Weingold AB, Seigal S, Stone MR: Intra-amniotic hypertonic solutions for induction of labor. Obstet Gynec 26:622, 1965

Document #5

Outpatient saline abortion: a review of 1,000 cases

RICHARD M. SODERSTROM, M.D., F.A.C.O.G., and GLEN E. HAYDEN, M.D., F.A.C.O.G.

From The Mason Clinic, Seattle, Washington

Abstract

Since December, 1970, when abortion reform was approved by public referendum, outpatient saline termination has been practiced at The Mason Clinic in Seattle, Washington. A review of the first 1,000 cases produced results more favorable than those usually presented. When these results are compared with those for 50 patients who had inpatient intra-amniotic dinoprost terminations, the incidence of serious complications is significantly smaller for outpatient saline terminations of pregnancy. One hundred cc of 24% saline is instilled transabdominally into the amniotic sac. In accordance with state law, this procedure is completed in the physician's office. After appropriate postinjection observation, the patient returns home until labor begins. Once labor is established, the patient reports to the hospital labor room, where she is observed until spontaneous expulsion occurs. There have been no serious complications. In the opinion of the authors, this lack of serious complications results from the following factors: a small volume of saline is instilled; "routine" use of intravenous oxytocin augmentation has been eliminated, thus preventing iatrogenic abruptio placentae syndrome; measures to promote early delivery because of economic pressures are eliminated; and the retained placenta rate is 4 to 5 times less than with intra-amniotic dinoprost.

12 Advances in Planned Parenthood 98 (1977)

Since 3 December, 1970, voluntary outpatient saline abortion has been practiced in the state of Washington. The decision to provide this service followed an abortion referendum passed on 3 November, 1970. That referendum required that rigid, vital statistics be kept on abortion procedures, including complications. The state also required that all midtrimester abortions be terminated in a licensed hospital. A legal interpretation obtained from the state Attorney General's office allows the initiating procedure (instillation of saline, hypertonic glucose, etc.) to take place in an outpatient environment.

Since 3 December, 1970, more than 4,000 midtrimester abortions have been performed in Washington State. At least 80% have been aborted following intra-amniotic hypertonic saline techniques. This paper reports the experience of the Virginia Mason Medical Center in the performance of midtrimester abortion. It will review the first 1,000 cases using an outpatient hypertonic saline method and compare the results with the first 50 inpatient cases using an intra-amniotic prostaglandin method.

Materials and methods

All patients requested voluntary abortion on the initial visit. Each patient was seen for a complete examination and counseled as to the decision-making process. All were required to listen to a "Saline Abortion" tape recording which describes the technique, benefits, alternatives, and complications. Those patients in doubt were encouraged to reflect upon their decision. Many were referred to Seattle-King County Planned Parenthood for more extensive counseling. The age, marital status, and parity did not differ markedly from that reported by previous authors (1-4). Fourteen per cent were recipients of public assistance. In all cases, the terminations occurred between 15 and 18 weeks of gestation.

In October, 1974, dinoprost became available for intra-amniotic injection. Most of the patients selected for this method were referred from long distances, which made a rapid injection-to-expulsion time desirable. In accordance with Food and Drug Administration regulations, all injections of dinoprost occurred in the hospital, and the patients were not discharged until expulsion was complete.

Saline technique

For the first 358 cases, the injection technique described by Newhardt and Shulman (5) was followed. Between 150 and 200 cc of amniotic fluid was withdrawn, and 200 cc of 23.4% hypertonic saline was instilled. Later we became aware of the success of Singh (2) who used 5% hypertonic saline, and at this point we changed the procedure. No amniotic fluid was aspirated, and the injection volume was reduced to 100 cc of 23.4% hypertonic saline.

All injections were performed in an outpatient facility that was fully equipped with emergency equipment, oxygen, intravenous fluids, and other life-support materials. Under sterile conditions, using local anesthesia, a transabdominal amniotic tap was made with a 16 gauge Rochester-type catheter. Over a 5 minute time period, the saline was injected by syringe, which was withdrawn after every 10 cc injected to ensure free flow of amniotic fluid. After the injection, each patient was observed and monitored with frequent blood pressure measurements for 15 to 30 minutes, before being discharged. Patients were encouraged to listen again to the "Saline Abortion" tape to reinforce their knowledge of what to except and when to report to the hospital. Each patient was instructed to take her temperature 3 times a day and to report any fever over 100° F. When labor was established (a consistent 5 minute contraction pattern), she was to report to the hospital. In the saline-patient series, oxytocin was added only for desultory labor progress.

Dinoprost technique

All patients were injected using the catheter method described above, but as inpatients. The manufacturers' recommendations were followed; 40 mg were injected initially, followed by 20 mg every 12 to 24 hours after the first 24 hours if labor had not become established. In this series, oxytocin (40 units/liter) solution was used to initiate labor in the 'failed' cases and laminaria was also used in 4 of the cases.

TABLE I
Midtrimester abortion times

	Saline		Dinoprost	
	Percentage	Time	Percentage	Time
Usual expulsion time	66	< 56 hours	82	< 36 hours
Mode		42 hours		22 hours
Delayed expulsion time (> 5 days)	10	6–31 days	–	–
Mode		9 days	–	–

TABLE II
Midtrimester abortion complications

Complication	Saline	Dinoprost
	Percentage	Percentage
Retained placenta	7.3	32.0
Failed	0.0	8.0
Excessive blood loss	1.5	8.0
Transfusion	0.4	4.0
Severe side effects	0.1	4.0
Fever > 101° F	1.8	8.0

Results

Table I summarizes the success of the saline and dinoprost in providing the desired result. All of the saline abortion patients eventually aborted without intervention. The 1 patient whose labor was delayed for 31 days, spontaneously expelled the products of conception the day she was admitted for surgical intervention. Four dinoprost patients failed to establish labor after 2 repeat injections in 48 hours (Table II). In these 'failed' cases, labor was successfully initiated with high-dose oxytocin stimulation.

Retained placenta was defined as: any placenta which required surgical removal more than 12 hours after the fetus was expelled, or any situation in which hemorrhage forced surgical intervention. As reported by others, there was a significant rate of retained placenta in the dinoprost series (32%), as compared to 7% in the saline series (6). Excessive blood loss (greater than 500 cc) was also substantially higher in those patients in the prostaglandin series. Two patients required 4 and 6 units of blood respectively, whereas only 1 patient in the saline series required 4 units of blood.

Two patients in the saline series were discovered to have unsuspected dead fetuses at the time of injection. Each patient was admitted and observed, and tested for the development of coagulation deficiency. One patient developed symptoms of hypofibrinogenia; after laboratory confirmation, she was successfully treated with fresh, whole blood replacement. There were no disseminated intravascular coagulopathy syndromes in the dinoprost series.

Five dinoprost patients had severe systemic reaction – cardiac arrhythmias, bronchial spasm, intestinal and bladder spasm – all of which were considered quite frightening by both the patient and the attending physician. During the saline injection 1 patient experienced symptoms of intravascular injection of saline (headache, abdominal burning, and hypertension). The injection process was stopped, and rapid intravenous infusion of glucose and water was begun immediately. One week later a repeat saline injection was successful.

One dinoprost patient ruptured her mem-

branes shortly after injection. Labor did not ensue even after multiple attempts at oxytocin augmentation, and the patient's fever rose to 105° F despite administration of massive doses of antibiotics. Surgical evacuation was performed transcervically, without sequelae. Two dinoprost patients developed cervicovaginal fistulas, whereas none were observed in the saline group. It could be, that such fistulas did occur in the saline group but went unnoticed because of the infrequent need for surgical completion of the abortion in this group of patients.

Comments and discussion

Intra-amniotic dinoprost is an effective method of terminating midtrimester patients most of the time (7). Its desirability results from the short time between injection and expulsion, which reduces hospital "waiting time." Coagulation deficiency, seen occasionally with intra-amniotic saline methods, has not occurred in dinoprost patients, however, a high percentage of retained placentas, greater frequency of hemorrhage, and significant incidence of fever and infection add to its morbidity statistics.

Two objections to intra-amniotic saline methods are: a delayed injection-to-expulsion time, and the threat of disseminated intravascular coagulopathies. When the patient is admitted to the hospital before saline injection, the cost of the procedure is significant and, in a large-volume center, bed availability may become crucial. The emotional trauma of "waiting" certainly is real, and must be compassionately considered. However, outpatient injection of hypertonic saline, as described, has eliminated the cost of hospital-based delay. In fact, the average cost of this method is 43% less than that of the dinoprost series, for which hospitalization is required. In our series of 1,000 cases of midtrimester saline abortion, no complication could be attributed to this method of outpatient injection.

We feel that proper counseling of the saline-abortion patient alleviates the anxiety and fear of the "waiting period." Most patients who understand the economic advantages, and also the fact that medical assistance is available upon request when desired and needed, are content to await the inevitability of labor and expulsion.

But what of the coagulation problems? Two publications have proposed an interesting theory, which our series supports (3,8). Cohen and Ballard compared 2 groups of patients undergoing intra-amniotic saline abortion. The first group received oxytocin augmentation immediately after injection. The second group did not receive oxytocin augmentation. The incidence of coagulation-deficiency syndromes was significantly higher in the oxytocin-stimulated group. To explain this, they hypothesize – as we do – that the addition of oxytocin augmentation sets up a "mini" model of the iatrogenic abruptio syndrome. But what is the hurry? Our series refutes any medical reason to "get it over with". Spivak and others have demonstrated that alterations in blood coagulation factors occur in the first 24 hours after hypertonic saline injection; a normal state is then reestablished (9). If oxytocin augmentation is desirable, we recommend at least a 48-hour delay.

Summary

Outpatient saline abortion has been a successful method of midtrimester abortion. Significant complications have been minimal, far fewer than those in a small series of patients receiving the intra-amniotic dinoprost. Although the outpatient abortion method delays the injection-to-expulsion time, the marked reduction in cost and the excellent hospital utilization justifies this approach.

References

1. Tietze C, Lewit S: A national medical experience: the joint programs for the study of abortion (JPSA) – in The abortion experience; Edited, by Osofsky HJ, Osofsky JD. Hagerstown, Maryland: Harper & Row, 1973
2. Singh KB, Schulman H: Techniques of abortion by three percent and five percent saline amnioinfusion. Advances in Planned Parenthood Vol 10, No 2:114-118, 1975
3. Brenner WE, et al: Induction of therapeutic abortion with intra-amniotically administered prostaglandin F2 alpha. Am J Obstet Gynecol Vol 116, No 7:923-930, 1972
4. Berger GS, Edelman DA, Kerenyi TD: Oxytocin administration instillation to abortion time and morbidity associated with saline instillation. Am J Obstet Gynecol Vol 121, No 7:941-946, 1975

5. Neuhardt S, Schulman H: Techniques of abortion. Boston: Little Brown, 1974, 74-87
6. Bolognese RJ, Corson SL: Interruption of pregnancy – a total patient approach. Philadelphia: Williams & Wilkins, 1975, 139-140
7. Corson SL, Bolognese RJ: Intra-amniotic prostaglandin F2 alpha to induce midtrimester abortion. Am J Obstet Gynecol Vol 117, No 1:27-34, 1973
8. Cohen E, Ballard CA: Consumptive coagulopathy associated with intra-amniotic saline instillation and the effect of intravenous oxytocin. Obstet Gynecol Vol 43, No 2:300-303, 1974
9. Spivak JL, Spangler DB, Bell WR: Defibrinogenation after intra-amniotic injection of hypertonic saline. N Engl J Med Vol 287:321, 1972

Document #6

David A. Grimes, MD
Willard Cates, Jr., MD, MPH

The brief for hypertonic saline

Existing data challenge the hypothesis that prostaglandin $F_{2\alpha}$ is the safest available abortifacient. This comparison of $PGF_{2\alpha}$ results with those of hypertonic saline suggests that the prostaglandin produces a faster but less safe abortion.

Although prostaglandins have been heralded as the "Cinderella drugs" of the 1970s, experience with prostaglandin $F_{2\alpha}$ ($PGF_{2\alpha}$) for second-trimester abortion more closely resembles the tale of the emperor's new clothes. For several years, many in the medical community[1] have regarded use of intra-amniotic $PGF_{2\alpha}$ alone as the safest method for second-trimester abortion, especially for high-risk patients.[2] Based largely on theoretical considerations, this belief has flourished in the absence of convincing evidence and in the face of mounting data to the contrary. As noted by the editor of *The New England Journal of Medicine*, "There are no absolute truths in any natural science, only hypotheses that are more or less satisfactory and therefore more or less durable."[3] The hypothesis that $PGF_{2\alpha}$ alone is the abortifacient of choice for second-trimester abortion is no longer satisfactory and hence should probably be discarded.

In this article we compare the two most widely used abortifacients in the US: hypertonic saline and $PGF_{2\alpha}$. We document the present use of these agents, summarize the literature concerning them, compare the risks of death associated with each, and suggest careful monitoring of future applications.

Dr. Grimes is assistant chief, abortion surveillance branch, Center for Disease Control, and clinical assistant professor of gynecology and obstetrics, Emory University School of Medicine, Atlanta; Dr. Cates is chief, abortion surveillance branch, CDC.

Current use of $PGF_{2\alpha}$ and saline

Despite its predominance in the abortion literature of the 1970s, $PGF_{2\alpha}$ used as the sole abortifacient apparently accounts for a minority of second-trimester abortions in the US each year.[4] In 1977, approximately a sixth of the second-trimester abortions were induced by $PGF_{2\alpha}$ instillation (Table I). In that year, saline instillation accounted for more than twice as many second-trimester abortions as did $PGF_{2\alpha}$. In the interval from 16 to 20 weeks' gestation, saline was used about twice as often as $PGF_{2\alpha}$, whereas at later stages saline was used approximately five times as often. The smaller proportion of $PGF_{2\alpha}$ abortions at $\geq$21 weeks may reflect concern over the possibility of live-born fetuses.

Review of the literature

We know of 18 studies published or reported since 1973 that have compared intra-amniotic $PGF_{2\alpha}$ and saline as abortifacients (Table II).[5-22] Since our review of 15 reports,[23] three additional ones have been published.[20-22] These studies range from retrospective chart reviews to multicenter, prospective, random-

Table I. Legal second-trimester abortions, by procedure.*

Type of procedure	Weeks' gestation							
	13-15		16-20		≥21		Total	
	No.	%	No.	%	No.	%	No.	%
Dilatation and evacuation	13,190	73.3	3,796	16.7	604	12.7	17,590	38.7
Saline instillation	3,001	16.7	11,385	50.1	3,055	64.3	17,441	38.3
Prostaglandin instillation	1,089	6.0	5,845	25.7	600	12.6	7,534	16.6
Hysterotomy/hysterectomy	153	0.8	209	0.9	37	0.8	399	0.9
Other	454	2.5	1,287	5.7	429	9.0	2,170	4.8
Unknown	119	0.7	221	0.9	27	0.6	367	0.7
Total	**18,006**	**100.0**	**22,743**	**100.0**	**4,752**	**100.0**	**45,501**	**100.0**

*Based on 1977 data from 28 states; excludes abortions with gestational age unknown.[4]

ized trials. Numbers of subjects studied ranged from 20 to 11,254.

Dosage regimens varied widely for different investigations. For $PGF_{2\alpha}$, 40 mg was the most common dose used; for saline, *Laminaria* tents or oxytocin were used to augment abortions in several studies.

The strongest advantage of $PGF_{2\alpha}$ evident from these reports is its speed as an abortifacient. The shortest mean induction-to-abortion time observed was 14 hours (with oxytocin augmentation). In contrast, 18 hours was the shortest time associated with saline augmented by *Laminaria* tents and oxytocin.

No clear pattern emerges regarding efficacy in producing abortion. Because definitions of "failed abortion" ranged from 24 to 120 hours, assessing the efficacy of these abortifacients is difficult. In those 17 studies for which failure rates were reported, eight showed that saline resulted in a higher percentage of pregnancies unaborted at the end of the observation period than did $PGF_{2\alpha}$; six showed the opposite; two found equal percentages; and in one no comparison could be made.

Incomplete abortion occurs more often with $PGF_{2\alpha}$ instillation. Rates as high as 63 per 100 abortions were reported by Kee and others.[13] In 11 reports, $PGF_{2\alpha}$ was associated with a higher rate of incomplete abortion than saline, whereas the converse was true in only three.

Both major and minor complications appear to be more frequent with $PGF_{2\alpha}$ instillation. Because second-trimester abortion is a relatively safe procedure, however, only large studies have the statistical power to detect differences in low complication rates that may be clinically important. Hence, we focus on statistically significant differences found in the nine studies with approximately 100 or more subjects in each group.

The first of these studies, by Edelman and colleagues, found that $PGF_{2\alpha}$ was associated with a higher rate of gastrointestinal side effects and a lower rate of fever.[10] Next came the report of the largest randomized clinical trial, performed by the World Health Organization (WHO).[13] Its conclusions were misleading. The authors noted that although the rates for hemorrhage, blood transfusion, and surgical re-evacuation associated with $PGF_{2\alpha}$ were higher than with saline, these differences were not significant. On the contrary, each difference was highly significant ($P<0.001$). Although this was not stated by the authors, the WHO data showed $PGF_{2\alpha}$ associated with significantly higher rates of vomiting, diarrhea, dyspnea, flushing, and chest pain.[24]

Berger and Edelman noted a lower rate of fever with $PGF_{2\alpha}$, but found no other significant differences.[14] Kee and associates did observe higher rates of vomiting, diarrhea,

and administration of parenteral narcotics with $PGF_{2\alpha}$. But their patients spent less time in the hospital.[18]

We performed the largest multicenter study thus far, confirming the data of the WHO trial.[16] We found the relative risk of hemorrhage associated with $PGF_{2\alpha}$ 3.1 times higher than that of saline. Similarly, the relative risk of requiring re-evacuation was 1.3 times higher. Rates of fever, endometritis, convulsions, antibiotic administration, major operative treatment, and readmission to a hospital also were significantly higher with $PGF_{2\alpha}$.

Robins's study incorporated oxytocin and *Laminaria* augmentation for all abortions.[19] Aside from a higher rate of incomplete abortion with $PGF_{2\alpha}$, no differences between the two methods emerged.

Bhatt and colleagues confirmed the higher risk of hemorrhage associated with $PGF_{2\alpha}$.[20] They also reported a higher rate of unpleasant GI side effects.

The 1978 report from the Indian Council of Medical Research[21] resembles the WHO study[13] in that both contain conclusions that seem to contradict the data presented. Table IV of the Indian report compares intra-amniotic saline instillation with an aggregate of abortions by several prostaglandin agents administered by several routes. The data demonstrated significantly higher rates of hemorrhage (threefold risk), postabortal bleeding (twofold risk), wound sepsis (sevenfold risk), cervical injury, and minor complications with $PGF_{2\alpha}$. After documenting the significantly higher complication rates of the prostaglandin regimens, the authors concluded paradoxically that "in general, prostaglandins were found to be safer than other methods for inducing mid-trimester abortions."[21]

Finally, Pahl and Lundy found $PGF_{2\alpha}$ to be associated with higher rates of re-injection, live-born fetuses, and GI side effects. These findings led them to conclude that "intra-amniotic $PGF_{2\alpha}$ alone, with or without laminaria, was not ideal."[22]

Risk of death with $PGF_{2\alpha}$ and saline

Instillation of $PGF_{2\alpha}$ appears to be associated with a risk of death similar to saline's. In the US, from 1972 to 1977, instillation of $PGF_{2\alpha}$ (and other agents) had an average death-to-case rate of 21 per 100,000. Saline instillation, on the other hand, had a rate of 16.[25] However, because the number of deaths is small and because the denominator for the $PGF_{2\alpha}$ abortions includes some procedures done with other agents, these rates should be interpreted with caution. Thus, available data are inadequate to assess the comparative risk of death associated with these agents.

Conclusive evidence?

The use of $PGF_{2\alpha}$ for second-trimester abortion is based largely on its potential advantages over saline. These include fewer cardiovascular side effects, absence of changes in clotting factors, lack of a sodium load, no risk of hypernatremia, and absence of tissue damage from inappropriate administration.[26] $PGF_{2\alpha}$, however, has been associated with rare but serious cardiac problems: two healthy young women have died within minutes after receiving intra-amniotic $PGF_{2\alpha}$, and another sustained severe ventricular arrhythmias.[23] Despite the lack of coagulation factor changes associated with saline, $PGF_{2\alpha}$ is associated with hemorrhage about three times more often than saline. Most women obtaining second-trimester abortion are young and healthy, and they can tolerate the solute load with hypertonic saline. The risk of hypernatremia with saline solution has probably been overstated in the literature; in the US only one woman has been reported to have died of this cause since 1972.[23] Thus, the theoretical advantages of $PGF_{2\alpha}$ over saline appear less compelling today than when first proposed.

$PGF_{2\alpha}$ produces abortion faster than saline but at significant cost: more GI side effects, higher complication rates, and increasing numbers of live-born fetuses.

The list of disadvantages, however, is

Table II. Comparative studies of intra-amniotic prostaglandin $F_{2\alpha}$

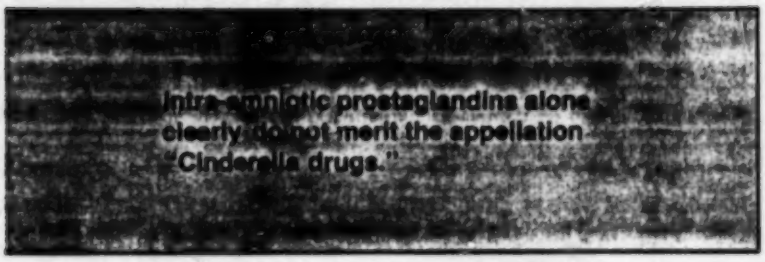
Author	Year of publication	Type of study	Number of patients	Abortifacient dose	Mean induction-to-abortion time (hr)	Failure to abort (%)	Incomplete abortion (%)	Significant differences in complications and treatments associated with PG
Corson et al[5]	1973	Retrospective	P_1=10	P_1=20 mg with serial increments	P_1=26	P_1=0	P_1=40	—
			P_2=10	P_2=30 mg + 25 mg	P_2=25	P_2=30	P_2=10	
			P_3=40	P_3=30 mg with serial increments	P_3=21	P_3=3	P_3=28	
			P_4=20	P_4=40 mg + 40 mg	P_4=21	P_4=0	P_4=45	
			P_5=20	P_5=40 mg with serial increments	P_5=18	P_5=5	P_5=25	
			S =40	S =23–47 gm	S =34	S =8	S =35	
Lauersen et al[6]	1974	Prospective, nonrandomized	P=10	P=20 mg with serial increments	P=15	P=10	P=20	—
			S=10	S=40 gm + oxytocin	S=20	S=0	S=10	
Bostofte et al[7]	1976	Prospective, nonrandomized	P=25	P=25 mg	P=37	P=8	P=0	—
			S=25	S= ≤40 gm	S=46	S=28	S=0	
Nielson et al[8]	1975	Prospective, randomized	P=16	P=40 mg + oxytocin	P=14	P=0	NS	—
			S=16	S=15–30 gm + oxytocin	S=22	S=31		
Risk et al[9]	1975	Retrospective	P=37	P=variable	NS	P=0	P=16	—
			S=570	S=30–50 gm		S=3	S=9	
Edelman et al[10]	1976	Multicenter, prospective, randomized	P_1=128	P_1=50 mg	P_1=20[2]	P_1=7	P_1=38	Higher rates for GI side effects; lower for fever
			P_2=114	P_2=25 mg with serial increments	P_2=17[2]	P_2=2	P_2=35	
			S=130	S=40 gm	S=26[2]	S=1	S=26	
Harrison and Souma[11]	1976	Retrospective	NS	P=40 mg + laminaria	P=19	NS	P=30	—
				S=21–32 gm	S=28		S=16	
Ragab and Edelman[12]	1976	Prospective, randomized	P_1=50	P_1=50 mg	P_1=22[2]	P_1=2	P_1=58	Higher rates for vomiting, diarrhea, and pelvic pain (P_1); lower for nausea only
			P_2=50	P_2=25 mg with serial increments	P_2=20[2]	P_2=2	P_2=24	
			S=50	S=40 gm	S=26[2]	S=2	S=41	
World Health Organization[13]	1976	Multicenter, prospective, randomized	P=717	P=25 + 25 mg	P=20	P=13	P=34	Higher rates for hemorrhage, blood transfusion, surgical re-evacuation, dyspnea, flushing, chest pain
			S=796	S=40 gm	S=30	S=19	S=32	
Berger and Edelman[14]	1977	Retrospective	P=100	P=40 mg	P=25[2]	P=0	P=51	Lower rate for fever
			S=100	S=40 gm	S=35[2]	S=4	S=35	

versus hypertonic saline for second-trimester abortion.*

Author	Year of publication	Type of study	Number of patients	Abortifacient dose	Mean induction-to-abortion time (hr)	Failure to abort (%)	Incomplete abortion (%)	Significant differences in complications and treatments associated with PGF
Kee et al[15]	1977	Prospective, randomized	P_1=99 P_2=98 S=98	P_1=50 mg P_2=25 mg with serial increments S=40 gm	P_1=26 P_2=26 S=39	P_1=5 P_2=1 S=10	P_1=58 P_2=63 S=53	Higher rates for vomiting, diarrhea, and parenteral narcotics; shorter mean length of hospitalization.
Grimes et al[16]	1977	Multicenter, prospective, nonrandomized	P=1,241 S=10,013	P=variable S=usually 40 gm	P=25 S=29	P=8 S=2	P=36 S=28	Higher rates for fever, endometritis, hemorrhage, convulsions, antibiotic administration, major and minor operative treatments of complications, readmission to a hospital
Stroup[17]	1977	Prospective, nonrandomized	P_1=100 P_2=22 S_1=24 S_2=37	P_1=40 mg + laminaria P_2=40 mg + laminaria + calcium gluconate S_1=40 gm S_2=40 mg + laminaria	P_1=17 P_2=18 S_1=30 S_2=21	P_1=1 P_2=0 S_1=4 S_2=0	P_1=34 P_2=36 S_1=42 S_2=30	Lower rate for fever
Smith et al[18]	1978	Multicenter, prospective, nonrandomized	P=89 S=1,207	NS	NS	P=10 S=7	NS	Higher rates for hemorrhage
Robins[19]	1978	Retrospective	P=700 S=170	P=40 mg + oxytocin + laminaria S=40 gm + oxytocin + laminaria	P=17 S=18	P=1 S=1	P=26 S=10	—
Bhatt et al[20]	1978	Prospective, randomized	P=100 S=100	P=40 mg + 20 mg S=NS + oxytocin	P=27 S=20	P=10 S=0	P=34 S=19	Higher rates for hemorrhage and GI side effects
Tejuja et al[21]	1978	Multicenter, prospective, nonrandomized	P=1,259 S=507	P=variable agents and routes S=NS	NS	P=15 S=4	NS	Higher rates for hemorrhage, postabortal bleeding, wound sepsis, cervical injury, and minor complications
Pahl and Lundy[22]	1979	Retrospective	P=346 S=439	P=40 mg + laminaria S=20–50 gm	P=21 S=34	P=3 S=4	P=19 S=11	Higher rates for reinjection, live-born fetuses, and GI side effects

P = Prostaglandin $F_{2\alpha}$; S = saline; NS = not specified
*$p < 0.05$
†Median time

*Adapted with permission from Corson SL, Bolognese RJ, Mercie J.[3]



growing. PGF$_{2\alpha}$ is associated with a higher rate of incomplete abortion and subsequent re-evacuation procedures than saline. With PGF$_{2\alpha}$, about 50% of women have nausea, vomiting, or diarrhea. Also, a higher proportion of women require re-injection of abortifacient than with saline. Cervicovaginal fistula formation appears more frequent.[27] PGF$_{2\alpha}$ is more expensive and more difficult to store. Moreover, the incidence of live-born fetuses appears five to 40 times higher than with saline.[23] And the live-born fetus has emerged as one of the most difficult medical, ethical, and legal problems in medicine today.

Prostaglandin F$_{2\alpha}$ is being used less today as a primary abortifacient and more as an augmenting agent in combination with saline or urea. Also, newer prostaglandins have been approved for extrauterine administration. But as an early investigator of prostaglandins cautioned in 1971, "the safety of prostaglandins is not yet established. . . . The initial spectacular results with prostaglandins in abortions have been followed by the usual natural history of new drugs, i.e., reports of failures and complications."[28] Thus, before these newer regimens supplant present techniques, large-scale comparative studies should document that they are safer than available alternatives.

The intra-amniotic PGF$_{2\alpha}$ story shows that caution is warranted. Although prostaglandins may yet prove to be "Cinderella drugs" in reproductive medicine, intra-amniotic PGF$_{2\alpha}$ alone for second-trimester abortion clearly does not merit such an appellation. PGF$_{2\alpha}$ produces abortion faster than saline but at a significant cost: more GI side effects, higher complication rates, and increasing numbers of live-born fetuses. We believe this is too high a price to pay. It may be time to cease admiring the emperor's new clothing when the existing literature suggests he is parading only in his underwear. □

REFERENCES

1. Palomaki JF: Abortion techniques: What are their risks and complications? Contemp Ob/Gyn 9:73, 1977
2. Wolf JA, Rubinstein L: The use of prostaglandin F$_{2\alpha}$ for second trimester abortion in patients with pre-existing medical complications. Adv Planned Parenthood 12:193, 1978
3. Reiman AS: On controversy in medicine. Pharos, Jan 1978, pp 18-22
4. Center for Disease Control: Abortion Surveillance 1977, issued September, 1979
5. Corson SL, Bolognese RJ, Merola J: Intra-amniotic prostaglandin F$_{2\alpha}$ to induce midtrimester abortion. Am J Obstet Gynecol 117:27, 1973
6. Lauersen NH, Wilson KH, Beling CG, et al: Comparison of prostaglandin F$_{2\alpha}$ and hypertonic saline for induction of midtrimester abortion. Am J Obstet Gynecol 120:875, 1974
7. Bostofte E, Stakemann G, Stocklund KE: A comparison of termination of pregnancies in the 2nd trimester induced by intraamniotic injection of hypertonic saline, prostaglandin F$_{2\alpha}$ or both drugs. Acta Obstet Gynecol Scand (suppl) 37:47, 1976
8. Nielson KR, Gregersen E, Larsen JF, et al: Prostaglandin F$_{2\alpha}$ and oxytocin compared with hypertonic saline and oxytocin for the induction of second trimester abortion. Acta Obstet Gynecol Scand (suppl) 37:57, 1975
9. Risk A, Mootabar H, Porta PJ, et al: Second trimester abortions. Review of four procedures. NY State J Med 75:1022, 1975
10. Edelman DA, Brenner WE, Mehta AC, et al: A comparative study of intra-amniotic saline and two prostaglandin F$_{2\alpha}$ dose schedules for midtrimester abortion. Am J Obstet Gynecol 125:188, 1976
11. Harrison JR, Souma JA: A comparison of saline and prostaglandin abortions at the Medical Center of Central Georgia. J Med Assoc Ga 65:53, 1976
12. Ragab MI, Edelman DA: Midtrimester abortion. A comparison of intra-amniotic prostaglandin F$_{2\alpha}$ and hypertonic saline. Int J Gynaecol Obstet 14:393, 1976
13. World Health Organization Prostaglandin Task Force: Comparison of intra-amniotic prostaglandin F$_{2\alpha}$ and hypertonic saline for induction of second-trimester abortion. Br Med J 1:1373, 1976
14. Berger GS, Edelman DA: A clinical comparison of prostaglandin F$_{2\alpha}$ and intra-amniotic saline for induction of midtrimester abortion. Ann Chir Gynaecol Fenn 66:55, 1977
15. Kee Sh, Lean TH, Vengadasalam D, et al: The safety and efficacy of intra-amniotic instillation of saline and two prostaglandin F$_{2\alpha}$ dose schedules for midtrimester abortion. Presented at the 7th Asian Congress of Obstetrics and Gynaecology, Bangkok, Thailand, Nov 20-25, 1977
16. Grimes DA, Schulz KF, Cates W Jr, et al: Midtrimester abortion by intra-amniotic prostaglandin F$_{2\alpha}$. Safer than saline? Obstet Gynecol 49:612, 1977
17. Stroup PE: Medical termination of midtrimester pregnancy in a community hospital. J Med Soc NJ 74:747, 1977
18. Smith RG, Palmore JA, Steinhoff PG: The potential reduction of medical complications from induced abortion. Int J Gynaecol Obstet 15:337, 1978
19. Robins J: A clinical comparison of intra-amniotic prostaglandin F$_{2\alpha}$ and intra-amniotic hypertonic saline for midtrimester pregnancy termination. Adv Planned Parenthood 13:27, 1978
20. Bhatt RV, Pachauri S, Koshy E, et al: Midtrimester abortion with prostaglandin and hypertonic saline—A comparative study. Int J Gynaecol Obstet 16:254, 1978
21. Tejuja S, Choudhury SD, Manchanda PK: Use of intra- and extra-amniotic prostaglandins for the termination of pregnancies—Report of multicentric trial in India. Contraception 18:641, 1978
22. Pahl IR, Lundy LE: Experience with midtrimester abortion. Obstet Gynecol 53:587, 1979
23. Grimes DA, Cates W Jr: The comparative efficacy and safety of intra-amniotic prostaglandin F$_{2\alpha}$ and hypertonic saline for second-trimester abortion. A review and critique. J Reprod Med 22:248, 1979
24. Cates W Jr, Grimes DA, Schulz KF, et al: World Health Organization studies of prostaglandins versus saline as abortifacients. A reappraisal. Obstet Gynecol 52:493, 1978
25. Cates W Jr, Grimes DA: Morbidity and mortality from second trimester abortion: A decade's perspective, in Berger GS, Brenner WE (eds): *Second Trimester Abortion: Perspectives After a Decade of Experience* (in press)
26. Brenner WE: The current status of prostaglandins as abortifacients. Am J Obstet Gynecol 123:308, 1975
27. Lowensohn R, Ballard CA: Cervicovaginal fistula. An apparent increased incidence with prostaglandin F$_{2\alpha}$. Am J Obstet Gynecol 119:1057, 1974
28. Speroff L: The prostaglandins—Enthusiasm and caution in equal doses. Hosp Prac 6:9, 1971

Outpatient Intra-amniotic Injection of Hypertonic Saline

THOMAS D. KERENYI, MD

From the Department of Obstetrics and Gynecology, The Mount Sinai School of Medicine of the City University of New York, and the Mount Sinai Hospital, New York, New York

IN VIEW OF PROFOUND CHANGES in both the philosophy and practice of interruption of unwanted pregnancies, and the current trend toward liberalized abortion laws, a critical review of present procedures seems timely (3,11,12,14,15).

Two principle concerns should be kept in mind: a) *good obstetric management* of such cases; and b) a *practical* approach to the problems involved.

Our experience in New York State, in implementing the first completely liberalized abortion law, will be relied upon heavily by other areas as they look toward changing their laws. Certain elements of that experience make it mandatory that we give serious attention to exploring feasible alternatives to prior "standard" procedures.

For example, the number of patients currently seeking abortion during the midtrimester surpasses the available hospital beds. In consequence, a study was undertaken to determine the practicability of ambulatory procedures at this period of gestation.

In my opinion, only two of the new techniques have proved to be lasting additions to the existing gynecologic armamentarium: during the first trimester, vacuum curettage, and during the second trimester, saline induction (intra-amniotic instillation of hypertonic solution, popularly known as the "salting out" procedure). Both techniques originated in Eastern Europe and began gaining acceptance in this country only a few years ago (8). (Incidentally, this trend coincides historically with the changing attitude regarding abortions in the respective geographic areas.) Both procedures have unique features which can give the gynecologist greater flexibility in management than is possible with traditional techniques.

Vacuum curettage under local anesthesia is well suited for ambulatory interruption of [illegible] trimester pregnancies, while the "salting out"

procedure has virtually replaced hysterotomy as the method of choice during the second trimester.

The following considerations guided us in planning a study of the feasibility of also performing the saline induction procedure on an ambulatory basis.

In New York, even with several months warning of enactment of the new abortion law, most hospitals still were unprepared to handle midtrimester abortions. The temporary measures, hurriedly designed in many instances, provided inferior patient care, and were insufficient to cope with the number of applicants. The resulting situation practically defeated the intent of the law, in terms of providing easy access to competent service.

During the first few months, patients wandered from hospital to hospital. Many may have been denied treatment because of long waiting lists. This situation added humiliation to the patient's mounting anxiety. Based upon my own experience cited below, I have believed for some time that health facilities other than hospitals could adequately perform saline induction for midtrimester pregnancies on an ambulatory basis, thereby relieving overcrowded circumstances. To test the validity of this approach, a series of 50 patients were handled on a completely ambulatory basis outside the hospital.

The technique used and the management designed for this series of ambulatory patients were based on 10 years' experience with saline induction at the Mount Sinai Hospital of New York City (Fig 1). The good results and low complication rate seem to support the contention that saline induction can be well managed in a specialized

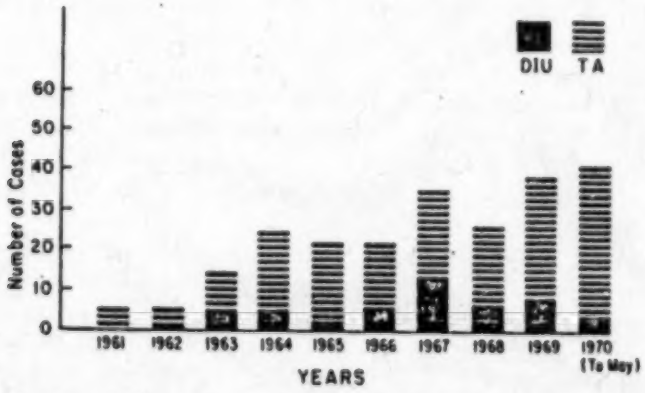


Fig 1. Results of 10-years' experience with saline induction at Mount Sinai Hospital of New York City.

health facility other than a hospital, provided that properly trained personnel are available. Considerable time and expense were saved, and all parties involved expressed satisfaction with the ambulatory arrangement.

The total number of hypertonic instillations performed, since this technique was first applied in 1961 until July 1970, exceeded 300 (8). Approximately one-fifth of these abortions were performed in cases of fetal death in utero (DIU) for the induction of missed labor. These cases are inherently complicated and have been discussed elsewhere in detail (6). However, several of the reported serious incidents encountered in cases of DIU have been indiscriminately attributed to "salting out" in general (4,9,13,18). This is as unwise as would be combining complications of midforceps with those of outlet forceps. Amniocentesis performed on an uncomplicated pregnancy in midtrimester represents a different and lesser surgical challenge than one performed in a case of DIU (1,5,7,16,17,19–21). This review concentrated on saline induction for abortion in midtrimester, not on induction of labor in cases of fetal death in utero. A brief documentation of the review of these cases will precede the presentation of the ambulatory series.

REVIEW OF SALINE INDUCTION ON HOSPITAL INPATIENTS BEFORE THE NEW LAW

Excluding the 56 cases of DIU's, 250 hypertonic instillations were collected from the records of the Therapeutic Abortion Committee. Approximately 50 of the cases reviewed were excluded because of insufficient accurate technical data; none had resulted in death or significant complications. The remaining 200 cases yielded the following statistics (Table 1).

Since the data were collected retrospectively, criteria to designate

Table 1. Results of Saline Instillation in 200 Therapeutic Abortions

Type patient	No. of cases	Average age	Parity	Gestation (wk)	Average ml Out	Average ml In	Latency (hr)	Labor (hr)	Instillation/abortion time (hr)
Multipara	81	29.4	1.5	18.5	195	210	29.2	4.3	35.3
Nullipara	119	20.2	0	17.6	192	209	32.1	5.6	37.1
All cases	200	24.1	.15	18.0	193	209	30.1	5.3	36.5

the onset of labor were difficult to establish at times. The overall instillation–abortion time interval, however, agreed well with those published by other groups (1,5,7,16,17,19–21).

Oxytocin stimulation was not used in the majority of cases, and the few cases where it was used (seldom exceeding 40 IU/1000 ml bottle) were not sufficient to evaluate whether the time required for expulsion of the uterine contents was shortened. Larger doses (10–20 ampules/bottle), presently used by other groups, have not been tried.

The most significant difference between these induced abortions and spontaneous ones has been the absence of hemorrhage. Blood loss was only estimated, not measured; therefore, accurate documentation is difficult. However, no transfusions were needed –unlike the DIU cases.

Increasing familiarity with the procedure compelled fewer physicians to keep patients NPO or to start intravenous infusions for the procedure. Similarly, the postinstillation observation time diminished significantly.

Thirst was a frequent complaint soon after salt instillation was completed and oral fluids were encouraged. Serum electrolyte changes described by Anderson and Turnbull in patients kept under "strict metabolic conditions" (2) were insignificant in our patients (Fig 2).

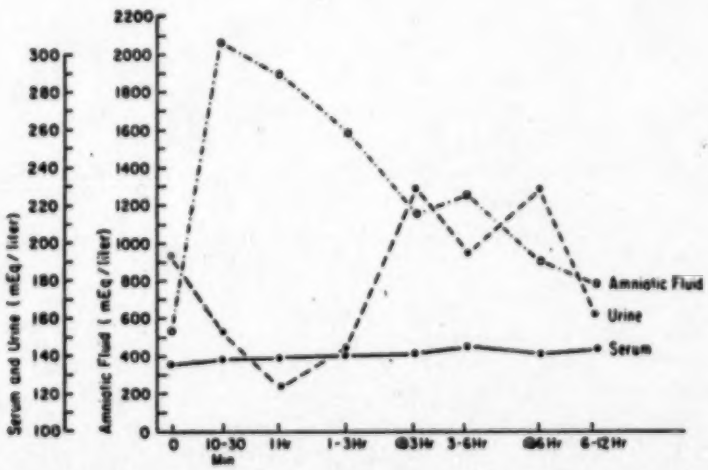


Fig 2. **Concentrations of sodium in serum, urine and amniotic fluid.**

Electrolytes (Na, K, Cl) were measured in the serum as well as in the urine and amniotic fluid in 10 patients (10). The serum sodium averaged 135 mEq/liter before the procedure. The small rise to 140 mEq/liter within an hour after the intra-amniotic instillation of the hypertonic solution was not exceeded at later stages (Fig 2). The difference between our series and the cases presented by Anderson and Turnbull is attributable to the *free* oral fluid intake of our patients.

With few exceptions, 200 ml ± 50 ml of 20 per cent NaCl was used because the few cases of 50 per cent glucose instillations had discouraging results (eg "missed labor", intrapartum fever, etc.). It was learned that greater amounts of hypertonic saline might occasion too rapid absorption and hypernatremia (9); lesser amounts led to prolonged latency or missed abortion.

The complications encountered are listed in Table 2. The 10 cases listed as "amniocentesis failure", were included to remind the reader of the importance of patient selection. Criteria have been enumerated in several previous publications (1,5,7,16,17,19–21). Interestingly, two patients in whom amniocentesis failed, aborted spontaneously several weeks later. Both had multiple "bloody taps" at the time the attempt failed.

These results and the overall experience with saline induction appeared sufficiently encouraging for an ambulatory trial.

Table 2. Complications

Cause	No. of cases	Percentage
Bloody tap/loss of free flow postponed tap	16	6.4
Acute abdominal pain	4	1.6
Hypotension, agitation, etc.	7	2.8
Ascites	0	0.0
Premature rupture of membranes	8	3.2
Prolonged latency	17	6.8
Pre- or intrapartum fever	7	2.8
Postpartum fever	10	4.0
Retained placenta (curettage)	28 (21)	11.2 (8.4)
Amniocentesis failure (wrong patient selection)	10	4.0

AMBULATORY SERIES

A regular doctor's office was rented and modified for our purpose. It consisted of the usual reception area and waiting room, and two

examination rooms. In addition to the usual equipment, one room contained a uterine aspirator, autoclave and emergency tray. The other larger room was outfitted with two couches and a curtain divider, IV pole and a small nurse's desk.

Laboratory test results (complete blood count, urinalysis, blood type and Rh) were available before the patient was first examined. The procedure was explained to the patient. Amniocentesis and the infusion of the hypertonic saline followed immediately.

No premedication was used. The abdominal or pubic hair was not shaved. The skin was sprayed with iodine, and a circumcision drape placed over the lower abdomen. A small skin wheel was raised, and the abdominal wall infiltrated with a total of 5 ml of 2% lidocaine (Xylocaine). The site for puncture was not limited to the midline. The uterus was palpated bimanually prior to the procedure, to select the area under which the uterine cavity seemed to be the most "cystic" and free of fetal parts and consequently could be assumed to be the unobstructed path to amniotic fluid. The correct site as indicated by a clean tap was found to be directly related to experience.

For the tap, an 18-guage, 3¼-inch disposable spinal needle was used routinely. If the needle alone did not assure the free flow of clear amniotic fluid (4 of 50 cases), a teflon catheter was threaded through the needle to prevent "loosing" the amniotic space. Actually, since the size of the lumen is reduced by the catheter, the exchange is considerably slower. Yet when free flow is not easy to maintain, the catheter is essential in preventing the deposition of hypertonic solution in the wrong compartment. If free flow could not be assured, no infusion of hypertonic solution was carried out. Instead, the procedure was postponed for 4–14 days.

The saline solution was infused by drip technique, utilizing standard intravenous equipment; no syringe or pressure infusion was ever applied. Patients were questioned about headache, dizziness, buzzing or tingling sensation in the lips or tongue or at the needle site during the infusion. The solution bottle was lowered repeatedly to check for a clear back flow. Thus, accidental infusion outside the amniotic sac, the single greatest risk of this procedure, was reduced to a minimum. When the infusion was complete, the obturator was replaced before the needle was removed. Manual pressure with a folded 4 × 4 gauze pad held by the patient was applied at the puncture site. These measures were designed to prevent even a few drops of saline from leaking into the peritoneal cavity which is highly sensitive. After five minutes, a small dressing was placed on the puncture site and the patient was allowed to get dressed. Then she was observed for 30

minutes in the waiting room, given instructions and allowed to leave the facility.

Instructions caution the patient to expect thirst within a few hours, a possible increase in abdominal girth and irregular cramping. No restrictions were imposed on oral intake or physical activity. Patients were told that regular labor-like contractions were to be expected after a 24–36-hour latency period, at which time they were to notify the assistant and make arrangements to return to the facility for completion of the second stage. If no labor ensued after 36 hours of latency, an intravenous infusion was started using 20 ampules of oxytocin per 1000 ml lactated Ringer's solution. Oral fluids were forbidden, thereafter, to prevent water intoxication.

Standing orders for sedation, meperidine (Demerol) and diazepam (Valium) were left with the assistant, who was then in constant attendance until the uterine contents were expelled. Intravenous infusions were not started routinely for those in spontaneous labor. If the placenta was not expelled within 30 minutes after the fetus, intravenous oxytocin infusion was begun.

The results and complications of such management are summarized in Table 3 and 4.

Immediately postpartum, in the hope of preventing breast engorgement, testosterone enanthate-estradiol valerate (Deladumone) was given intramuscularly.

Patients were discharged from the unit two to four hours after sedation received during labor wore off.

Patients were instructed to take their temperatures, orally, three times a day for one week and report any elevation over 100°. If fever occurred, patients were given antibiotics.

Contraceptive advice was offered, and prescriptions for oral agents, to be started one week post partum, were given. If an intrauterine device or diaphragm was desired, the patient was advised to see a gynecologist within 10–14 days.

DISCUSSION

The time from instillation to completion of abortion naturally varied somewhat from patient to patient; the average 35.2 hours (Table 4) for 50 ambulatory patients came quite close to the average 36.5 hours for hospitalized patients (Table 1). This figure reflects the similarity in basic management—that is, the waiting period for spontaneous onset of labor. In eight cases, intravenous oxytocin was started

Table 3. Complications in 50 Consecutive Ambulatory "Salting Out" Cases

Complication	No. of cases
Bloody tap (requiring second tap at different site)	4*
Severe abdominal pain with vasomotor symptoms	1 (10 min)
Dilatation and curettage	5†
Pitocin stimulation (drip infusion)	
for prolonged latency (>36 hr)	8
for placental retention (>30 min)	6
Transfusions	0
Hemorrhage (>500 ml EBL)	0
Heavy bleeding (>250 ml EBL)	2
Fever (>101.4° F)	1‡
Antibiotics used prophylactically	3

* Six bloody taps within 2 weeks in one case. Spontaneous onset of labor without use of hypertonic saline.

† Four of the 5 D and C's in the first 10 cases for retained placenta. Massive Pitocin infusion instituted then for retained placenta resulting in no D and C for the last 28 consecutive cases.

‡ Less than 36 hr controlled by oral antibiotics.

after 36 hours' latency. Although painful uterine contractions or cervical dilatation were absent, all of these patients had evidence of previous uterine activity. This was a characteristic "funneling" of the lower uterine segment with or without some dilatation of the external cervical os. Such funneling is invariably the result of antecedent contractions even though imperceptible to the patient. It should be looked upon as the equivalent of early cervical effacement before term, similarly reflecting prior uterine activity. It usually denotes myometrial

Table 4. Fifty Consecutive Cases of Ambulatory "Salting Out" Procedures

Age	Parity and no. patients	Gestation (wk)	Amniotic fluid out (ml)	NaCl (23%) in (ml)	Total abortion/ instillation time (hr)
20½	46 nullipara 4 secundipara	19.2	220 (60–350)*	220 (150–250)*	35.2 (9†–65)

* One case had only repeated bloody taps (6 within 2 weeks); no fluid withdrawn or salt instilled. Spontaneous onset of labor completed with five (5) hours of Pitocin stimulation.

† Brown fluid obtained. Probable DIU case. Shortest in normal pregnancy 15 hours.

readiness and increasing sensitivity to oxytocin stimulation. Without it, the duration of oxytocin stimulation will be proportionately longer or may even fail. Even though such a case was not encountered in this series, I have advised repeat saline instillation as an alternative in others seen in consultation.

The use of large doses of oxytocin, started shortly after saline instillation, is not suitable for ambulatory management. It may shorten somewhat the overall time interval from instillation to abortion; it proved unnecessary in the majority of our cases (84 per cent). Oxytocin drip was resorted to after 36-hour latency, mostly because of patient anxiety. If the unpredictability of onset of labor were as well accepted among midtrimester aborters as it is among full term patients, the anxiety factor would be less significant. Practical considerations also have played a role in setting a 36-hour limit for latency. Many of the patients were out-of-town referrals, and therefore a limited latency period was financially mandatory. In my opinion, it is very likely that the earlier use of oxytocin drip in the hospitalized patients has evolved from similar considerations.

Bloody taps disappointingly do not vanish completely even in experienced hands. Until uterine contents can be easily and accurately mapped out by some technique presently not available, bloody taps should hardly be considered a complication certainly not if choosing a different site at the same sitting will result in free flow of amniotic fluid. In my opinion, hysterotomy should be an absolutely remote consideration.

The one case of severe abdominal pain localized to the needle site merits some technical reproachment. The stylette of the needle had slipped off the sterile field, and the needle was withdrawn at the end of the infusion without replacing it. The resulting saline leak from the lumen could be 2–3 drops at most. The ensuing sharp pain from peritoneal irritation disappeared, within 10 minutes, spontaneously. This could have been avoided, however, had isotonic saline been injected by syringe before needle withdrawal.

The four curettages performed for retained placental portions in the first 10 patients led to modification in management. Instead of instrumental removal, an oxytocin drip was started when spontaneous expulsion of the placenta did not follow in 30 minutes. At first only one ampule per 500 ml bottle was used, which still necessitated instrumentation in one patient. Once the infusion rate was increased to 5–10 ampules (50–100 IU) per bottle, placental retention did not require surgical intervention.

In two patients the blood loss was estimated to be more than 250

ml but less than 500 ml. Massage of the fundus in one case, and oxytocin infusion and the expulsion of the placenta in another, were followed by cessation of the hemorrhage. No transfusions were required in any of the 50 cases.

Prescriptions for oral antibiotics, as prophylaxis, were given to three patients who had premature rupture of membranes and multiple vaginal examinations both pre- and intrapartum.

One patient reported a fever of 101.4° on the third day postabortum. She was treated at home with oral antibiotics and was afebrile in 36 hours.

No hospital admissions were reported. The follow-up was 100 per cent up to the second week and 82 per cent to the fourth week postabortum.

For many of the patients such ambulatory arrangement was the last resort to solve the problem of an unwanted pregnancy.

One-third of the patients were under 18 years of age, and one-half under 20. Four out of five were unmarried. Eighteen of the 50 patients did not know they were pregnant until they were in the second trimester. Such statistics are an unfortunate reflection on existing standards of sex education. Should the current law be changed to ban abortions for pregnancies over 12 weeks' gestation, most of these patients would be forced to carry a child they did not want, could not support, nor even provide with a father.

PRACTICAL SUGGESTIONS

With the experience gained in a large series of cases, including ambulatory as well as hospital inpatients, many possible complications can be anticipated and avoided. Those most frequently encountered are discussed, and appropriate therapeutic measures are suggested.

Immediate Complications

Bloody Tap

Bloody tap frequently is caused by insufficient needle insertion. The tip may imbed in the placenta or a myometrial sinus, producing venous-type bleeding. Deeper insertion often will lead to rapid clearing of fluid. Another site may be chosen if clear flow is not established. If the fluid is slightly blood-tinged by a previous bloody tap, it does not contraindicate, *per se*, the infusion of the hypertonic saline. If, however, repeated taps remain grossly bloody, it is advisable to post-

pone infusion for several days. In my opinion, pressure dressing or ice packing—advised by some—is probably not necessary. The interlacing fibers of the thick second trimester myometrium will quickly obliterate even large-bore needle tracts. Before a repeat tap is attempted, ultrasound tracings may be helpful in pinpointing the optimum site for amniocentesis. Refractory cases may remain unsolved until the aid of sonography is enlisted. In our experience, three postponements was the record number before a clear tap was obtained.

Cessation of Free Flow

Valve action of fetal parts may be corrected by changing the angle of the needle or by applying gentle side pressure on the fundus. Altering the depth of the needle tip often aggravates the situation, or results in dislodgment from the amniotic sac. Instead, insertion of polyethylene tubing should be considered. Restoration of free flow, although at a slower rate, is the usual result. If suction exerted by the syringe collapses the tube, gravity drainage may be preferred. Total evacuation of the amniotic fluid rarely is achieved or necessary. In some centers an even exchange rarely is attempted. Once free amniotic fluid flow is established, infusion of the solution follows. In my experience, such practice may result in premature rupture of the membranes or in too rapid dilution, which may lead to prolongation of the latency period or even to missed abortion.

If restoration of free flow is unsuccessful, and if dislodgment from the amniotic space is suspected, infusion of hypertonic solution must not be attempted. Instead, if X-ray facilities are readily available, roentgen contrast medium (eg, Hypaque) may be injected. Less than 30 ml rarely will help in recognizing the compartments just injected. In fact, equal amounts of *isotonic* saline may be added to disperse the dye for identification. Such procedures are especially helpful in cases of DIU, to avoid depositing the hypertonic solution in closed compartments of a macerated fetus. With a live fetus such developments are quite unlikely.

Acute Abdominal Pain, Rapid Pulse, Hypotension and Irritability

Acute abdominal pain is almost always the result of hypertonic fluid deposited on peritoneum. Isotonic saline or sterile water should be injected immediately through the needle to dilute the irritant. This is also useful when the needle is finally withdrawn, thereby avoiding the painful spillage of a few drops of concentrated solution.

Rapid pulse, hypotension, irritability and agitation has been observed in varying degrees following accidental intravascular infusion. Needle dislodgment should be ruled out. At the start of the infusion, unless free flow was never in question, it is advisable to observe the patient for a few minutes after 10–15 ml has been injected. Similarly, at the completion of the procedure, the infusion bottle should be lowered to check the back flow of fluid before the needle is withdrawn. The catastrophic complications resulting from direct rapid infusion of hypertonic solution into vascular compartments must be avoided. Postponing the infusion until there is a reaccumulation of fluid always is preferred to a "blind" infusion.

Delayed Complications

Ascites

The blunted sensorium of sedated patients may prevent the recognition of peritoneal irritation. If it occurs, however, either by maldeposition or back-leakage from the uterine cavity, massive extracellular fluid shift can be expected to dilute the concentrated solution (9). I have observed ascites exceeding four liters (9). The salt load absorbed from the peritoneal surfaces and the fluid shift from intravascular spaces may rapidly create dangerous degrees of hypernatremia. To prevent possible fatal cerebral dehydration, immediate hypotonic infusion must be started (4). Peritoneal dialysis should follow. Emergency serum sodium determinations may serve as therapeutic guidelines (4,10).

It is my opinion that general anesthesia is contraindicated for this procedure. Also, sedation should be kept light, to retain the most important indicator—the sensitivity of the peritoneum to noxious stimuli. Fluid restriction prior to the procedure has proved to be not only unnecessary but undesirable. As shown in Fig 2, the serum sodium concentration remained within normal limits when patients were allowed to drink fluids freely. It was also our impression that the level of anxiety usually aggravated by NPO orders occurred less frequently with free oral intake.

Late Complications

Premature Rupture of Membranes

Successful spontaneous completion of abortion has been observed despite premature rupture of membranes occurring 3–5 hours postin-

fusion. Although prolonged latency is more likely if premature rupture of membranes occurs, it is by no means the rule. Pelvic examinations should then be reduced to a minimum. Prophylactic antibiotics have not been used unless clinical evidence of infection developed.

Prolonged Latency

Prolonged latency phase with ruptured membranes probably should be avoided. It is difficult, however, to state categorically when oxytocin stimulation should begin. Without fever, 24–48 hours of waiting for the onset of labor after premature rupture of membranes, would probably suffice. More recently, even with intact membranes, oxytocin drip was started if the latency period exceeded 36 hours. To prevent water intoxication (the antidiuretic effect of oxytocin must be kept in mind), fluids must be restricted once the oxytocin drip is started. Lactated Ringer's solution with 100–200 IU oxytocin per 100 ml was used. Although it is a routine procedure at some centers, I do not recommend oxytocin stimulation after instillation of the hypertonic solution (7).

Pre- or Intrapartum Fever

Pre- or intrapartum fever, when suspected to be of uterine origin, should be treated vigorously with intravenous antibiotics and closely followed by oxytocin stimulation. Amniotomy may accelerate the progress of abortion and obviates the need of surgical intervention. After expulsion of the uterine contents, rapid postpartum defervescence is the rule even without subsequent curettage. Postabortal sepsis, although rare, is very similar to postpartum endometritis and should be treated similarly.

Rupture of Membranes

Membranes should not be ruptured artificially unless amnionitis is diagnosed. Hour-glassing of the amniotic sac into the vagina is frequent and should not be confused with full dilatation. It also has been noted that large numbers of patients will present with the breech. These immature midtrimester breeches compare unfavorably as dilating wedges to the cone of the unruptured amniotic sac, well applied against the cervix and therefore should be preserved as long as possible.

Live Born Fetus

Live born fetus has been described in third trimester inductions with anencephalic infants (21). In midtrimester "salting out" cases, however, I am aware of only two such incidents. Both occurred between 24–26 weeks' gestation and otherwise were uncomplicated cases with 56 and 73 hour total instillation–abortion time. The infants lived only for a few minutes. Other known cases with fetal survival were admittedly early third trimester (>26 weeks) cases. Fifteen consecutive cases monitored for fetal heart rate are illustrated in Fig 3. The majority of the fetal hearts are undetectable one hour following the deposition of the hypertonic solution in the amniotic sac.

Retention of Placenta

Retention of the placenta has been most frequently observed when stimulation of uterine contractility was elected. I prefer spontaneous completion of the expulsion of all the products of conception. However, if the fetus is expelled without subsequent extrusion of the placenta, I anticipate that the cervix may clamp down and I will make one attempt to combine fundal pressure with digital exploration of the uterine cavity before resorting to intravenous oxytocin infusion. If the placenta is undelivered in 30 minutes, oxytocin drip stimulation similar to that used for prolonged latency is recommended. If the placenta is still retained beyond 12 hours in spite of intravenous oxytocin, dilatation and curettage is advised.

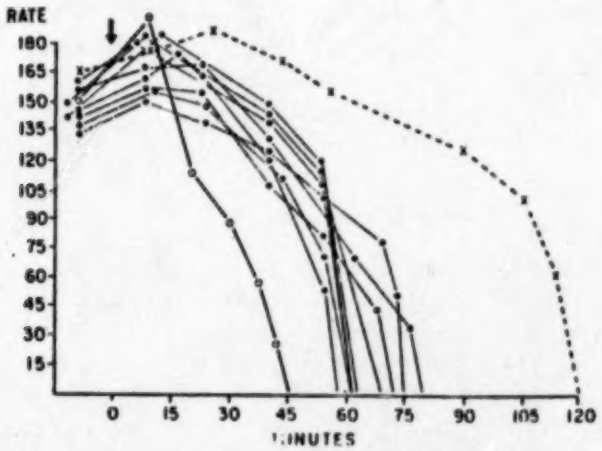


Fig :) tal heart rate.

Some centers routinely carry out curettage following expulsion of the conceptus. However, I have found this unnecessary. The duration of postabortal bleeding can be similar to postpartum bleeding although usually much shorter and scanter. The occasional need for a D and C would be adjudged by criteria similar to those of the postpartum period.

CONCLUSIONS

I feel that the experience and understanding gained during the 10 years of using the "salting out" technique allows the following conclusions:

1. The first part of the procedure can be safely performed by an *obstetrician*, experienced in this technique, as an ambulatory procedure (just as in a diagnostic amniocentesis).
2. Hypertonic solution must not be infused unless the amniocentesis is uncomplicated. If this is not the case, postponement and/or a different approach (eg, transvaginal, etc.) should be chosen.
3. With the proper patient selection
   a) normal intrauterine pregnancy of 14–24 weeks gestation
   b) avoidance of heavy sedation
   c) avoidance of general anesthesia

no need for emergency measures should arise.

4. If the guidelines are followed, and restraint dictated by common surgical practice is adhered to, none of the previously elaborated immediate complications will occur.
5. The late complications, not necessarily caused by faulty technique, are of such nature that they will require admission to the health facility, or develop in the already admitted patient. The likelihood of unusual complications requiring transfer to a hospital is extremely remote.

In my opinion *instillation* of hypertonic solution can be safely carried out as an ambulatory procedure. The second stage or actual abortion can be well managed in a specialized health facility other than a hospital, provided that properly trained personnel are available.

ACKNOWLEDGMENT

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1176 Fifth Avenue
New York, NY

REFERENCES

1. Alpern WM, Charles AC, Friedman EA: Hypertonic solution for termination of pregnancy. Obstet Gynec 100:250, 1968
2. Anderson ABM, Turnbull AC: Changes in amniotic fluid, serum and urine following the intra-amniotic injection of hypertonic saline. Acta obstet gynec scand 47:1, 1968
3. Brosset A: Induction of therapeutic abortion by means of a hypertonic glucose solution injected into the amniotic sac. Acta obstet gynec scand 37:519, 1958
4. Cameron JM, Dyan AD: Association of brain damage with therapeutic abortion induced by amniotic-fluid replacements: Report of two cases. Brit med J 1:1010, 1966
5. Csapo AI: The termination of pregnancy by the intra-amniotic injection of hypertonic saline, Year Book of Obstetrics and Gynecology, 1966–1967. Edited by JP Greenhill, Chicago, Year Book Publishers, 1966
6. Csapo AI, Jaffin H, Kerenyi TD, et al: Fetal death in utero. Amer J Obstet Gynec 87:892, 1963
7. Goodlin RC, McLennan CE, Choyce JM, et al: Therapeutic abortion with hypertonic intra-amniotic saline. Obstet and Gynec 34:1, 1969
8. Jaffin H, Kerenyi TD, Wood CE: Termination of midtrimester pregnancy and missed abortion. Amer J Obstet Gynec 84:602, 1962
9. Kerenyi TD: Hypernatremia following intrauterine instillation of hypertonic saline solution: Report of a case and discussion. Obstet and Gynec 33:520, 1969
10. Kerenyi TD: Unpublished data
11. Kerslake D, Casey D: Abortion induced by means of the uterine aspirator. Obstet and Gynec 30:35, 1967
12. Kovacs F: Eine einfache und verlabliche methode zur Schwangerschaft-sunterbrechung mach de 10. Woche. Abl Gynack 11:1098, 1948
13. Macdonald D, O'Driscoll MK, Georghegan FJ: Intra-amniotic dextrode—a maternal death. J Obstet Gynaec Brit Cwlth 72:452, 1965
14. Manabe Y: Abortion in midpregnancy by extraovular instillation of rivanol solution correlated with placental function. Amer J Obstet Gynec 103:232, 1969
15. Nilsson C-A: Vacuum-aspiration of uterine contents in legal abortion and allied conditions. Acta Obstet Gynec Scand 46:501, 1967
16. Pathak UN: Induction of labour by intraamniotic injection of saline. Amer J Obstet Gynec 101:513, 1968
17. Ruttner B: Termination of midtrimester pregnancy by transvaginal intra-amniotic injection of hypertonic solution. Obstet and Gynec. 28:601, 1966
18. Wagaatsuma T: Intra-amniotic injection of saline for therapeutic abortion. Amer J Obstet Gynec 93:742. 1965

19. Wagner G, Karker H, Fuchs F, et al: Induction of abortion by intraovular instillation of hypertonic saline. Dan med Bull 9:137, 1962
20. Weingold AB, Segal S, Stone MI: Intraamniotic hypertonic solutions for induction of labor. Obstet and Gynec 26:622, 1965
21. Wood C, Booth RJ, Pinkerton JHM: Induction of labor by intra-amniotic injection of hypertonic solution. Brit med J 2:706, 1962

4
Interruption of Pregnancy After Twelve Weeks' Gestation
Saline Abortion

THE SAFEST AND SWIFTEST METHOD of producing an abortion after 12 weeks of amenorrhea is by replacing the amniotic fluid with a hypertonic saline solution. At the present time this procedure does not have the unanimous support of obstetricians and gynecologists because of reported fatalities here and abroad. However, when these reports are analyzed, one or the other of several possible deficiencies is apparent: (1) The technique may be in question; for example, the physician has not demonstrated that he has injected the saline solution into the amniotic sac and therefore may have injected it into a blood vessel, the myometrium, or the peritoneal cavity. (2) An excessive amount of salt has been injected into the amniotic fluid. (3) Hypertonic glucose was used, resulting in *Clostridium welchii* sepsis. (4) The procedure was performed under general anesthesia so that the patient was unable to report symptoms of hypernatremia.

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S. Neubardt and H. Schulman, Techniques of Abortion 65, 99-104 (1972).

It will be recalled that when the amniotic fluid is removed and the saline solution instilled, on occasion the membranes rupture spontaneously at the end of the procedure. Despite this, the abortion usually occurs on time. However, if it does not, the pregnancy is usually terminated. Therefore, one could probably terminate the pregnancy and induce an abortion by merely removing the amniotic fluid, instilling the 40 gm of saline, and then removing it within 45 minutes. For insurance, we then instill 50 ml of 5% glucose in water with 1 million units of penicillin. This fluid will draw back into the uterus any salt that may have escaped into the maternal circulation.

To date, this approach has been 100 percent effective in a small group of patients with cardiac or renal disease. For this type of patient, consideration should also be given to the mechanical approaches to second trimester abortion utilized by the Japanese. (See Chapter 5.)

POSTINSTILLATION MANAGEMENT

The ideal management of the patient after she has received the instillation is unresolved. It is an issue that involves social, moral, and economic decisions on the part of both physician and patient and offers a severe challenge to traditional methods of delivery of health care.

In January, 1970, we began doing saline instillations on ambulatory patients. This decision was made because (1) the catheter technique eliminates the risks of serious acute hypernatremia; and (2) experience with intra-amniotic saline instillation on an inpatient basis in a municipal hospital as well as in a private hospital permitted the following observations:

1. Patients rarely had significant immediate symptoms, other than thirst, from the procedure.

2. Most patients aborted uneventfully.

3. Only 20–30 percent of the patients received medication for pain. By the time most patients could persuade a nurse to bring medication, the patient was completing the abortion.

4. In the early years, physicians were summoned when patients aborted. Recognizing the safety of the spontaneous process, the house staff began delaying their response and eventually merely instructed nurses what to do. In addition, the private gynecologist did not usually come back to the hospital just because his patient aborted, but expected the house or nursing staff to handle it, although neither was formally instructed as to what to do. Soon some nurses began to assume complete responsibility and only called the staff when there appeared to be a problem. Those physicians who attempted to assist the patients seemed to add to the morbidity. In their efforts to expedite matters, we noted avulsion of fetal parts and partial separation of the placenta.

5. Patients confined to a ward awaiting the abortion were often subjected to verbal and nonverbal condemnation by personnel on the unit. Our early experiences in caring for these patients convinced us that when the law was changed, such patients must be cared for in an isolated area by motivated personnel. The emotional aura surrounding abortion is electric, and it will be many years before these patients will be treated equitably in a general ward atmosphere. When labor begins after saline instillation, it is usually swift, and it is pure chance whether or not the woman will receive emotional or physical support.

6. In general, abortion occurred in one to three days.

If it did not, there were psychological pressures on the physician to do something to accelerate the process. No medical or nursing care is required during this period.

All of these considerations, added to the unavailability of hospital beds and the large number of patients seeking care after July 1, 1970, led us to institute an ambulatory saline abortion program. This type of approach seemed to have several advantages:

1. The patient is under observation initially, during the period of risk from hypernatremia or when immediate labor might occur. If neither occurs, she may then return home and await the onset of abortion.
2. The patient is provided with a supply of analgesics to be taken when she wishes, and is given adequate instruction as to how to do so. This is more likely to be effective than requests made to a busy nurse in an acute hospital ward.
3. It restrains the impulse of attendants to intervene in the process of abortion, a restraint which enhances safety.
4. Valuable time of the professional staff is conserved, and active patient care is restricted to the actual time of abortion. Pregnant women usually do not remain in hospitals awaiting labor unless there is significant coexistent disease.
5. The use of hospital beds in acute wards is limited to those patients with extraordinary problems.

Thus, we instruct our patients to return to the hospital to complete the abortion. A patient is told that if she accidentally aborts at home, she need not be alarmed. Stressing the safety of the spontaneous nature of the abortion can be a strong reassurance to the patient.

From our inpatient experiences we learned that many women aborted very rapidly after the onset of symptoms, and some aborted with minimal warning signs. We therefore feel that it is necessary to inform patients of this possibility before discharge and to instruct them as to what to do if they abort at home.

EXPERIENCE IN 674 PROCEDURES

From January to November, 1970, we performed 674 outpatient saline abortions in our unit. The vital statistics and medical results from this group of women are presented in Table 4-2.

We have been disappointed that we had lost 122, or 18 percent, of our patients to follow-up. Patients who did not report and were later contacted by telephone or letter appear to have aborted uneventfully, and we hope this is true for the remainder. The 122 patients lost to follow-up were those who gave false home addresses and telephone numbers. Presumably, some went to other hospital emergency rooms. If there have been serious problems, we have not been notified. We repeatedly inform and caution our patients about the necessity of their maintaining contact with us, but the social and psychological complexities of abortion sometimes lead to continued secretive behavior on the part of these women. We are happy to report that there has been continued improvement, and we now have follow-ups on better than 90 percent of our women.

The data on parity (Table 4-2) are of interest in that they shed some light on the reasons why women seek abortions. Those who have had no previous pregnancy are

usually single and are seeking abortion for social reasons. The next largest group are women with two or more children who are seeking abortion primarily because of failed contraception, or because of irregular sexual activity following a dissolved marriage. The relatively small number of women with more than four children speaks well for the inroads birth control programs are making in urban poverty populations.

Saline abortion has certain advantages. A second trimester pregnancy can be terminated by a single injection requiring 20–30 minutes, and no general anesthesia is required. We have found that approximately 80 percent of these women will abort in one to three days without requiring much medical support. The remaining women will be plagued by several problems: failure to go into labor in one week, retained placenta, endometritis, and incomplete separation of the placenta. There are no other methods reported in sufficient numbers with which we can compare relative morbidity figures.

The ideal method would be one in which some oral medication could be ingested and the abortion would be complete. However, it is not likely that nature will be thwarted that easily. Injection of a chemical into the amniotic sac is a good approach, but the perfect drug will be nontoxic to the mother, initiate labor within a few hours, and completely evacuate the uterus. Such a drug has not yet been discovered.

Abortion Utilization: Does Travel Distance Matter?

8 Family Planning Perspectives 260 (1976)

The further a woman must travel in order to obtain an abortion, the less likely she is to get one. Distance is especially disadvantageous to blacks, and most so to black teenagers. Distance discourages use among rural as well as urban women. Opening new clinics increases abortion use in nearby communities.

By James D. Shelton, Edward A. Brann and Kenneth F. Schulz

When abortion is not legally available in their own communities, some women will travel—even over considerable distances—to other communities in order to obtain safe, legal terminations of unwanted pregnancies.[1] It might be expected, however, that the additional time, money and ability to cope with the health system in an unfamiliar environment that are required would deter others from obtaining the abortions that they want. Furthermore, it has been asserted that the poorest, youngest and least sophisticated women would be the most disadvantaged by local unavailability.[2] A study of the relationship between distance and abortion utilization in New York State in 1970 and 1971, when women from many states had to travel to New York State to obtain legal abortions, showed that the greater the distance from New York, the lower the utilization of the state's abortion facilities.[3]

Following the U.S. Supreme Court 1973 abortion decisions, the availability and utilization of abortion in the United States increased markedly. Nevertheless, wide variations in the provision of abortion services have been observed for various localities, with abortion facilities in most states concentrated in one or two large metropolitan areas.[4] This in fact is the case in the state of Georgia. Although Georgia reported a ratio of 265 legal abortions per 1,000 live births in 1974, compared with a ratio of 246 for the nation as a whole,[5] the ratio ranged from 0 to 588 for the various Georgia counties.[6] In this article, we examine the effect of travel distance on this variation in Georgia. Furthermore, since it has been suggested that poor and very young women are still largely underserved by existing abortion facilities,[7] we also examine this effect on the abortion utilization of black women* and teenagers.

Method

Data on abortions by county of residence were obtained from the abortion certificates that are required by Georgia law for all abortions performed within the state. In 1974, the nine major abortion providers were all located in Fulton County, which contains the greater portion of Atlanta. Not surprisingly, 90 percent of all abortions performed in Georgia in 1974 were performed in either Fulton County or adjoining De Kalb County. For the purpose of this analysis, therefore, we considered only highway distance to Atlanta. Our units of analysis were the 159 counties in Georgia. The characteristics ascribed to the county were the resident abortion-to-live-birth ratio according to subgroup, and the shortest highway distance from the county seat to Atlanta. A number of the 159 counties are rather small. Therefore, whenever subgroups of the population were compared, counties were excluded in which there had been fewer than 10 births per year to any subgroup.

Residents of Alabama, North Carolina, South Carolina and Tennessee obtained 3,600 of the 22,000 abortions performed in Georgia in 1974. Presumably, this was because it was relatively easier to obtain abortions in Georgia, especially from the seven freestanding abortion clinics in Atlanta, than in these other states. Thus, it can be inferred that very few Georgia residents obtained abortions in these other states. A small number of residents of southern Georgia do obtain abortions in northern Florida. Through data obtained from the three major providers of abortion in Jacksonville and Tallahassee, Florida, we estimate that a maximum of 300 such abortions were performed in 1974. Such a small number would have little effect on our analysis. Nevertheless, in some of the following analyses we exclude all Georgia counties within 100 miles of either Jacksonville or Tallahassee.

Results

Figure 1 compares the abortion-to-live-birth ratio in 1974 for each county in Georgia. The general tendency is for abortion utilization to be highest in northwest Georgia around Atlanta and to decrease with distance from Atlanta. Some of the exceptions to this pattern are smaller urban areas which have some local abortion services (Richmond, Bibb, Muscogee, Dougherty, Chatham), and a few counties with branches of the state university system (Clarke, Baldwin, Bulloch). These counties have relatively high proportions of female college students, who, presumably, are more affluent and sophisticated than the average woman of the same age. Figure 2 presents the same data in the form of a scattergram, including the linear bivariate

James D. Shelton and Edward A. Brann are Medical Officers, and Kenneth F. Schulz is a mathematical statistician, Family Planning Evaluation Division, Bureau of Epidemiology, at DHEW's Center for Disease Control, Atlanta. Dr. Shelton had been assigned formerly to the Georgia Department of Human Resources, Division of Physical Health, Maternal Health Section.

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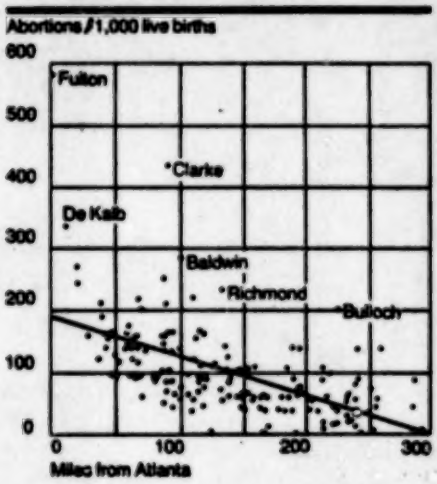
*Race, in this article, is used as a proxy for socioeconomic status, since there are no available data to measure differences by county for such socioeconomic variables as income and education.

Figure 1. Number of abortions per 1,000 live births, by county of residence, Georgia, 1974

Figure 2. Number of abortions per 1,000 live births for 159 counties in Georgia, by highway distance to Atlanta, 1974



regression line for all of the 159 counties.

Table 1 shows the results of the regression analysis in more detail. The analysis of the effect of distance on the abortion-to-live-birth ratio for all 159 counties yields a correlation coefficient (r) of −.569 (a perfect fit would be 1.0), and accounts for 32.4 percent of the variation in the abortion-to-live-birth ratio (r^2 = .324). Since we know that some Georgia residents obtained abortions in Tallahassee and Jacksonville in 1974, we excluded all counties within 100 miles of either of these Florida cities. The correlation remains highly significant (r = −.483). It is possible that the negative correlation of the abortion ratio with distance from Atlanta results from less acceptability of abortion in the more rural areas. However, if we examine only rural counties by excluding the 31 counties in any one of Georgia's Standard Metropolitan Statistical Areas, the correlation also remains highly significant (r = −.539). Once a distance of over 150 miles is reached, a further increase in distance appears to be much less of a handicap. For counties at that distance or more, the r value is only −.132 (not shown in table).

The differences in correlation for subgroups of the population are shown in Table 2, excluding counties with such small cell size that they produce highly

Table 1. Linear bivariate regression of the effect of highway distance on number of abortions per 1,000 live births, for selected counties, Georgia, 1974

County group	Correlation coefficient (r)*	Coefficient of determination (r^2)*	Unstandardized regression coefficient*
Total (N=159)	−.569	.324	−.61
128 counties in SMSAs†	−.539	.290	−.50
123 counties not within 100 miles of Tallahassee or Jacksonville	−.483	.233	−.67

*All significantly different from 0, F-test, $p < 0.001$.

†Standard Metropolitan Statistical Areas.

Table 2. Linear bivariate regression of the effect of highway distance on number of abortions per 1,000 live births, for selected groups of women,* Georgia, 1974

Selected group	Correlation coefficient (r)†	Coefficient of determination (r^2)†	Unstandardized regression coefficient†
All women	−.602	.362	−0.87
White	−.540	.292	−0.63
Black	−.651	.423	−0.79
Age ≥ 20	−.546	.298	−0.53
White	−.520	.270	−0.48
Black	−.571	.325	−0.71
Age 15-19	−.627	.393	−1.12
White	−.435	.189	−1.22
Black	−.677	.458	−0.89

*Includes only the 117 counties with at least 10 births for each subgroup.

†All significantly different from 0, F-test, $p < .001$.

variable measurements. (This exclusion yields an even higher correlation coefficient [r = −.602] than that shown in Table 1.) Two different measurements of the relationship between the variables are of particular interest. The first is the correlation coefficient (r), which measures how closely various points follow or fit the particular regression line (see Figure 2). The other is the unstandardized regression coefficient, which measures how much the abortion-to-live-birth ratio varies with distance *on the best fitted line.* For example, the unstandardized regression coefficient of −.67 for all women in the 117 counties with at least 10 births for each subgroup means that on the best fitted line the number of abortions declines by 6.7 per 1,000 live births for every 10 miles of distance from Atlanta. (The coefficient of determination [r^2] for women in these counties is .362; that is, distance accounts for 36.2 percent of the total variation in the abortion ratio.)

The effect of distance is more highly correlated for black women than for white women. This difference narrows when only women aged 20 or older are considered, but the difference between blacks and whites in the unstandardized regression coefficient increases slightly. The relationship for teenagers is more complex. When all subgroups are examined, travel distance is most highly correlated for black teenagers (r = −.677), but has the smallest correlation for white teenagers (r = −.435). Although the correlation coefficient is smallest for white teenagers, the unstandardized regression coefficient is actually higher for them than for any other group. Therefore, travel distance explains less than one-fifth of the variation in the abortion ratio among white teenagers, but, to the extent that the variation is explained, the effect is strongest for this subgroup—the number of abortions declined by 12.8 per 1,000 live births for every 10 miles of distance from Atlanta.

Changes in 1975

In early 1975, two new outpatient abortion facilities outside Atlanta were established. One was opened in Columbus (Muscogee County), 106 miles from Atlanta and near the Alabama state line; the other in Augusta (Richmond County), 139 miles from Atlanta, near the South Carolina border. In Table 3, we compare 1975 with 1974 data to see the effect on abortion ratios of introducing these facilities, both in the urban counties where the clinics are located and in the generally rural counties that surround them. In each of the areas where these new outpatient abortion facilities might be expected to increase abortion utilization, the abortion-to-live-birth ratio increased by at least twice as much as it did in the remainder of the state.* The percent increase in the surrounding *rural* areas was roughly the same as in the central urban counties of Muscogee and Richmond.

Table 3. Number of abortions per 1,000 live births for selected areas, Georgia, 1974-1975

Selected area	No. of abortions		
	1974	1975	% increase 1974-1975
Muscogee County	165.1	223.2	35.1
14 counties within 50 miles of Muscogee County	126.8	181.0	42.7
Richmond County	228.6	335.7	46.9
10 counties within 50 miles of Richmond County	87.8	123.3	40.4
Remaining 133 counties	215.2	253.0	17.6

Summary and Discussion

Our data indicate that the farther a woman has to travel to obtain an abortion, the less likely she is to obtain one. Our correlation coefficients were similar to those found by Monmonier and Williams for 1970 and 1971 in New York. Their r values ranged from −.45 to −.64.[8] The effect of distance is particularly strong for black teenagers, but the correlation is somewhat lower for white teenagers. One possible explanation is that the population of white teenagers may be thought of as being composed of two groups. The group of older, more affluent, more well-informed teenagers (such as most of the college students) may have relatively little difficulty in traveling considerable distances to obtain abortions. Some, in fact, may prefer to travel in order to maintain anonymity. For younger, less affluent, less well-informed teenagers, the effect of distance may be much more important.

The relationship between distance to Atlanta and abortion utilization persists despite the confounding influences of some smaller abortion facilities across the state and high utilization in counties with college campuses. It also remains when counties within 100 miles of the major northern Florida providers are excluded. One possible explanation for the observed differences in utilization of abortion is that rural women (who generally live farther away) may, in fact, simply desire or need fewer abortions. However, when only rural counties are included, the negative correlation is still strongly apparent. In addition, the opening of two new freestanding abortion clinics in two small *urban* counties resulted in approximately the same percent increase in use of abortion in the surrounding *rural* counties as in the urban counties where the clinics operated.

The time, money and effort needed to travel may not be the only impediment to utilization of a distant abortion facility. A woman who wants an abortion may simply not know of the existence or availability of an abortion provider outside her community. Operationally, however, the effect is probably the same. A woman who lives farther from abortion facilities will be less likely to obtain an abortion.

*For each of the four areas analyzed, the increase in the number of abortions to residents was significantly higher ($p < 0.05$) than for the remainder of the state.

References

1. Center for Disease Control, DHEW (CDC), *Abortion Surveillance, Annual Summary 1972,* Atlanta, 1974, Tables 4 and 5.

2. The Alan Guttmacher Institute (AGI), *Abortion 1974-1975: Need and Services in the United States, Each State and Metropolitan Area,* New York, 1976, p. 41.

3. M. S. Monmonier and A. V. Williams, "Abortion and Spatial Interaction: Temporary Migration to New York," *Proceedings of the Association of American Geographers,* 5:177, 1973.

4. AGI, *Provisional Estimates of Abortion Need and Services in the Year Following the 1973 Supreme Court Decisions: United States, Each State and Metropolitan Area,* New York, 1975; and AGI, 1976, op. cit.

5. CDC, *Abortion Surveillance, Annual Summary 1974,* Atlanta, 1976, Table 2.

6. Georgia Department of Human Resources, Division of Physical Health, "Induced Abortion Report, Georgia, 1974," Atlanta, 1975 (mimeo).

7. E. Weinstock, C. Tietze, F. S. Jaffe and J. G. Dryfoos, "Abortion Need and Services in the United States, 1974-1975," *Family Planning Perspectives,* 8:58, 1976.

8. M. S. Monmonier and A. V. Williams, 1973, op. cit.

Document #10

Obstetricians' Attitudes And Hospital Abortion Services

12 Family Planning Perspectives 26 (Jan./Feb. 1980)

By Constance A. Nathanson and Marshall H. Becker

Summary

Since legalization of abortion in 1973, U.S. hospitals have played a decreasing role in meeting the demand for abortion services; most abortions today are performed in freestanding nonhospital clinics. Data from a survey of Maryland hospitals and affiliated obstetrician-gynecologists suggest that physicians' attitudes are a major factor affecting the number of hospitals in which abortions are performed and the number of abortions performed by these hospitals.

The survey found that private, non-Catholic hospitals whose affiliated physicians oppose expansion of fertility-related health services or report high levels of disturbance at participation in abortion procedures are much less likely to perform abortions, or to perform very many, than hospitals whose affiliated physicians have opposite attitudes. The effect of physician attitudes on the number of abortions performed in the hospitals is quite strong, and is independent of the effects of hospital size, number of medical departments and community need for abortion services.

However, the range of abortion-related services provided (such as contraception and counseling for abortion patients) is not significantly influenced by physicians' attitudes. The reason for this difference may be that most private, non-Catholic hospitals do not have a major institutional commitment to perform or to prohibit abortions, so that the level of abortion services is largely determined by the beliefs and practices of attending physicians. The range of services, however, may be primarily under administrative rather than physician control.

These findings suggest that neither resource availability nor organizational capacity explains the failure of hospitals to provide abortions to women in need in their communities; rather, the negative attitudes of individual physicians affiliated with these hospitals are primarily responsible.

Hospitals are much less likely to perform abortions if affiliated physicians dislike performing abortions or oppose expanding fertility-related services. But doctor attitudes do not affect the range of abortion-related services offered.

Background

The mode of delivery of abortion services that has evolved in the United States since the U.S. Supreme Court legalized abortion in 1973 is markedly different from the pattern characteristic of other minor surgical procedures: Tonsillectomies, routine D&Cs and most deliveries occur in hospitals, but six out of 10 abortions are performed in freestanding nonhospital clinics. Indeed, since 1973, the proportion of all abortions that are performed in hospitals has declined by about one-third, while the role of freestanding clinics has increased correspondingly.[1] These national patterns of abortion service delivery are even more marked in Maryland, where the proportion of hospital abortions declined by 57 percent between 1973 and 1976, while the proportion of abortions performed in clinics increased by more than four times.[2] Furthermore, as in other states, hospital-based abortion services in Maryland are concentrated in relatively few hospitals; 68 percent of hospital abortions reported to the Maryland state health department in 1976 were performed in six hospitals.

The purpose of this article is to evaluate the degree to which selected characteristics of hospital structure and physicians' attitudes might help to account for the limited response by hospitals to the increased demand for legal abortion services.

Innovation, Hospital Organization And Physicians' Attitudes

Inequities in hospital abortion provision, and the constraints on women's access to abortion-related services created by restrictive hospital policies, have been of continuing concern to policy makers and other health professionals in recent years.[3] Several authors have suggested that conservative physician attitudes strongly influence hospital abortion policies.[4]

To understand the reasons for variation in hospital abortion policies and procedures, a conceptual framework must be developed on which the selection of potential explanatory variables can be based.

Abortion has been practiced for centuries to control reproduction. But it has been legal in most states and, therefore, an available option for hospitals, only since the 1973 Supreme Court decisions. Abortion as a legitimate hospital service can, therefore, be conceived of as an "innovation," in Rogers's sense of an "idea, practice, or object perceived as new" by the potential adopter.[5]

Research on hospitals' adoption of new programs and services has identified several organizational variables that tend to be positively associated with innovation.[6] These include hospital size, financial resources, centralization of power or influence, professional subspecialization and mechanisms facilitating access to information sources outside the hospital itself. It is important to

Constance A. Nathanson is Associate Professor of Population Dynamics at The Johns Hopkins University School of Hygiene and Public Health. Marshall H. Becker is Professor of Health Behavior and Health Education at the University of Michigan School of Public Health. The research upon which this article is based was supported by a grant from NICHD (no. HD 09269). An earlier version of this paper was presented at the 1978 annual meeting of the American Public Health Association.

distinguish between social and technological innovations in developing hypotheses to explain hospital innovations; attitudes of hospital policy makers play a major role in the adoption of social innovations.[7]

Abortion services clearly represent a social innovation. Empirical support for the role of attitudinal variables in hospitals' adoption of a range of social innovations,[8] combined with recent data pointing to the importance of physicians' attitudes toward abortion in structuring their behavior toward abortion patients seen in private practice,[9] leads us to hypothesize that the abortion-related attitudes of obstetricians affiliated with a given hospital will be associated with the number of abortions performed by that hospital, as well as with the hospital's development of abortion-related services. These hypotheses are examined here, controlling for characteristics of hospital organization found to be associated with innovation in earlier work. Since the need for abortion services in the hospital's catchment area may also be expected to influence the level of provision, a measure of need is also included as a control variable.

Methodology

The hypotheses described above were tested by analyses of data on the abortion services provided by acute-care general hospitals in Maryland. These analyses required the development of indices to measure three sets of variables: the hospital's level of participation in abortion services; the abortion-related attitudes that characterize each hospital's obstetrical staff; and (as controls) a measure of the need for abortion in the community, and the hospital's size and other organizational dimensions. Except where otherwise indicated, all data refer to the year 1976.

The actual numbers of abortions performed in each hospital during 1976 were obtained from the records of the Abortion Surveillance Program conducted by the Maryland State Department of Health and Mental Hygiene. For hospitals in which any abortions were performed during 1976, data on the specific abortion-related services provided were collected by personal interview with the appropriate hospital representative (usually the chief of obstetrics). These interviews were completed in 30 of the 31 eligible hospitals.

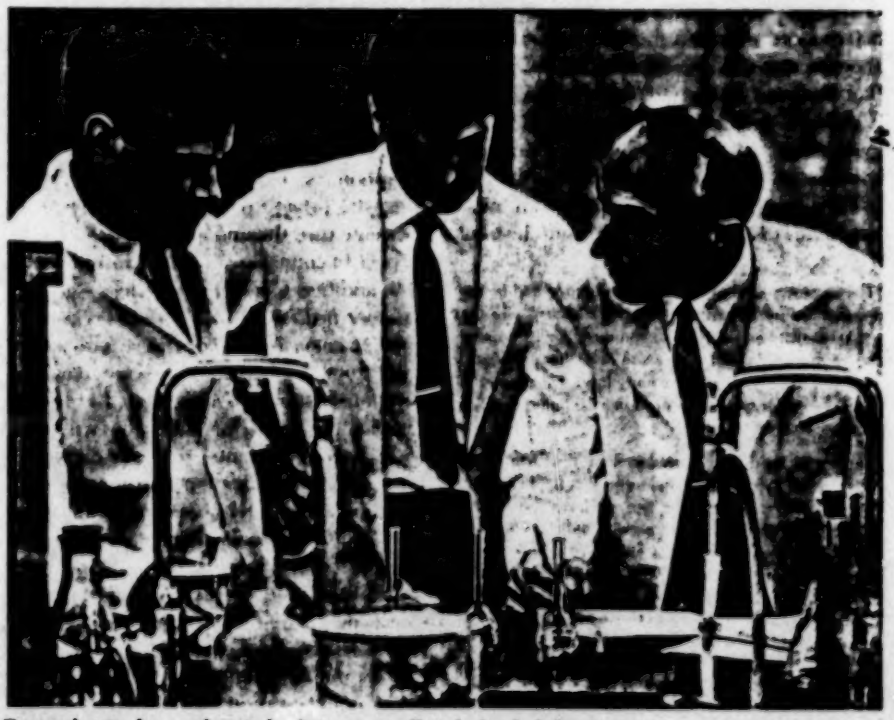
Three scales describing the *range* of abortion-related services provided, the *institutionalization* of abortion services within the hospital and the *restrictions* placed on receipt of abortion services were created from the interview data.

Information on obstetricians' attitudes toward abortion and related issues was obtained as part of a survey of all obstetricans with any private practice in Maryland.[10] Data were collected to measure both their opinions on policy issues regarding the control of reproduction and their personal reactions to the abortion procedure. Sixty-six percent of the eligible obstetricians responded to these questions. Data on the hospital affiliations of the obstetricians were also obtained, permitting aggregation of physician attitudes by hospital.* Each hospital is described by two indices based on these data: degree of liberalism of affiliated obstetricians with respect to the expansion of fertility-related services (a five-point scale combining responses to 10 attitude items); and the affiliated physicians' psychological response to abortion (a four-point scale describing the frequency with which the obstetricians reported that they were personally disturbed by participation in abortion procedures).†

Three organizational characteristics of the hospitals are introduced as control variables: hospital size, number of medical departments and medical school affiliation.

- Hospital size (measured here by number of beds) is the single variable most consistently associated with innovation in earlier studies.[11] It is highly correlated in the present study (in analyses not shown) with the hospital's annual dollar expenditures and with its average investment in capital equipment, and may be considered as an overall reflection of the resources available for innovation within the hospital.
- Organizational diversity, or specialization, increases access to new knowledge, skills and interests, all of which are likely to facilitate innovation;[12] this variable is indexed by the number of separate medical departments within the hospital.
- Medical school affiliation also acts to promote awareness of new developments outside the hospital environment.[13] This affiliation, in addition, provides a resource for performing abortions that is unavailable to nonteaching hospitals, namely, house staff. The presence or absence of a teaching affiliation is published in the Hospital Guide issue of the *Journal of the American Hospital Association*.[14]

The fourth control variable, estimated need for abortion services in the hospital's catchment area (defined as the county in which the hospital is located), is based on resident abortion rates in the six states (including Maryland) with the highest such rates in 1976. These rates are used as the basis for calculating what the levels of abor-



Doctors' attitudes, not hospital policies, most affect the level of abortion services.

*The attitude indices are based on data from a median number of 4–5 obstetricians per hospital. The range is from one (in five hospitals) to 27.

†For more detailed descriptions of these scales, see reference 9, C. A. Nathanson and M. H. Becker, 1977.

tion would be if availability and accessibility of services were equally broad throughout the country. The estimated levels are then applied, in the form of rates, to population data for each county, giving an estimated "need" figure for each of the 23 Maryland counties and Baltimore city.* All hospitals within a given county are assumed to experience the same level of need.

Results

In 1976, there were 53 acute-care general hospitals in Maryland. Seven of these were operated by the federal government and six were Catholic. None of the Catholic hospitals, and only one of the federal hospitals, performed any abortions in 1976. The distribution of abortions among these 53 hospitals is presented in Table 1. Sixty-eight percent of all abortions in Maryland hospitals in 1976 were performed in 11 percent of hospitals—the six hospitals that reported 300 or more abortions in 1976. The range of abortion services provided by the hospitals that performed abortions is shown in Table 2. The hospital's chief of obstetrics and gynecology was interviewed to determine whether or not the hospital, in addition to offering first-trimester abortions on an inpatient basis (defined as the minimum level of service), also provided ambulatory abortion procedures, second-trimester abortions, abortion counseling and contraceptive services for abortion patients. For each service offered, respondents were asked whether it was available to private patients, service (ward) patients or both. As shown in Table 2, 11 types of service were described; hospitals were classified on a scale from one to 11 according to the *cumulative number* of these services that they provided (for example, hospitals that offered five of the 11 services would be assigned a scale point of five).

Table 1. Distribution of abortions in Maryland hospitals, 1976

No. of abortions per hospital	No. of hospitals	% of all hospital abortions
0	22	0.0
<100	13	7.1
100–199	6	8.7
200–299	6	16.6
>300	6	67.7
Total	53	100.0

The survey data indicate that hospitals which offer a less frequently provided service also offer all those that are more frequently provided. For example, the four hospitals that permit private patients to return to the hospital for contraceptive services also offer all of the other services listed in Table 2. Similarly, the 21 hospitals that perform second-trimester abortions for service patients also perform them for private patients and offer ambulatory abortions to patients in both service categories.

The data presented in Table 2 demonstrate that almost half of all the Maryland hospitals where abortions are performed offer no services beyond the abortion itself. When related services (contraception and abortion counseling) are provided, service patients are much more likely to get them than private patients. These findings are consistent with results reported by Lerner and his colleagues from a survey of New York City abortion facilities carried out in 1972.[15] The difference in services offered to nonprivate and private patients may arise because it is assumed that the latter group receive these services from the private physician who admitted them. If this assumption is incorrect, then, as Lerner suggests, private patients may receive less adequate care than nonprivate patients with respect to counseling and contraception.

In addition to *range* of services, scales to measure *institutionalization* of services and *restrictiveness* of services were also developed from the hospital interview data. Institutionalization is indicated by special training programs for staff who will work with abortion patients; separate outpatient or inpatient facilities for abortion patients; and separate staff for abortion patients. The level of institutionalization in each hospital is described in terms of an eight-point cumulative scale constructed in the same way as the range-of-services scale; each hospital is scored from zero to eight according to the number of special facilities for abortion patients it provides. Few hospitals have made more than the minimal institutional investment in abortion services. The special programs most frequently cited were prior preparation or training of staff (mentioned in nine hospitals) and separate outpatient abortion clinics for service patients (provided by seven hospitals).

Finally, restrictiveness of services is measured by a 10-point cumulative scale reflecting the number of restrictions placed by the hospital on access to abortion. These restrictions may take the form of geographical limitations (only patients living within certain geographical boundaries are accepted), requirements for consent of a married woman's husband or the parents of a minor, or limitations on the number of abortions performed within a certain period. A higher score indicates a larger number of restrictions. Among hospitals that do perform abortions, about one-third restrict their services in some fashion. The most frequently encountered restriction is a request for spousal consent before the abortion can be performed.

Relationships between the number of abortions performed by Maryland hospital providers in 1976 and the extent of abortion-related services that they provide are shown in Table 3.† (In this and subsequent tables, Catholic and federal hospitals are excluded from the analysis. Catholic hospitals are prohibited by church doctrine from performing abortions. Hospitals operated by the federal government represent a

Table 2. Range of abortion services provided by hospitals that performed any abortions, Maryland, 1976*

Service provided	Hospitals	
	No.	%
1st-trimester inpatient abortion, private and service patients	30	100.0
Ambulatory abortion		
Private patients	25	83.3
Service patients	25	83.3
2nd-trimester abortion		
Private patients	21	70.0
Service patients	21	70.0
Contraception		
Private patients	6	20.0
Service patients	16	53.3
Return to hospital for contraception		
Private patients	4	13.3
Service patients	15	50.0
Abortion counseling		
Private patients	4	13.3
Service patients	12	40.0

*Excludes one hospital that performed abortions but did not provide data on abortion-related services.

*The estimates used in this article were prepared by the research staff of The Alan Guttmacher Institute. In the actual calculations, "need" was estimated for six population subgroups defined by age and race; these estimates were then aggregated to the county level. Details on the methodology for estimating need may be found in reference 1.

†Certain of the indices employed in this article are highly skewed in their original form; that is, there is an extreme difference between the smallest and largest value of the variable. These skewed variables include number of abortions, need for abortion by county, and hospital size. So that the results of the correlation and regression analyses presented in this article would not be unduly affected by individual extreme values, each of the skewed variables has been transformed by replacing the original value with its square root. This transformation has no effect on the rank order of items defined by a particular variable; it simply reduces the amount of variation in a constant manner.

distinctive subgroup, both organizationally and in their clientele; in Maryland, only one of the seven federal hospitals performed any abortions in 1976. Private acute-care hospitals that performed no abortions in 1976 are also excluded from Table 3, since these hospitals, by definition, do not provide any abortion-related services.)

In this table, the degree of association between two variables can range from .00, indicating a total absence of relationship, to 1.00, indicating that the variables are perfectly associated. As Table 3 shows, the number of abortions performed is highly correlated with the range of abortion-related services provided and the institutionalization of those services. That is, hospitals that do relatively few abortions are less likely to offer a range of related services (such as contraception and counseling) or to have made special provision for the needs of abortion patients (such as separate outpatient clinics). Among hospitals that perform *any* abortions, restrictiveness is not related to the number of abortions performed. This is a somewhat surprising result. However, other evidence indicates that in these hospitals, the imposition of restrictions may be more a reflection of bureaucratization than of an ideological commitment to the restriction of abortion services (see Table 5, page 30).

The next step in this presentation is to account for the variations in hospitals' abortion services, and to test the hypothesis that the attitudes of obstetricians affiliated with each hospital are an important determinant of that hospital's abortion service pattern.

Previously reported analyses of these physician data[38] have identified two independent components of obstetricians' abortion-related attitudes: a philosophical dimension, reflecting the physician's beliefs about the propriety of liberal policies toward provision of reproductive health services; and a psychological dimension, reflecting personal disturbance when participating in abortion procedures. The relationship of each of these factors to the number of abortions performed and to the range, institutionalization and restrictiveness of services provided by each hospital is presented in Table 4.

A favorable physician attitude toward the expansion of fertility-related services is positively associated, and disturbance at abortion procedures is negatively associated, with the number of abortions performed in the hospitals with which these physicians are affiliated. In addition, hospitals in which the physicians more frequently report disturbance are less likely to offer a range of abortion-related services (second-trimester abortions, abortion counseling and contraceptive services for abortion patients). The other indices of abortion services that were examined (institutionalization, restrictiveness) are not significantly associated with these attitudinal dimensions.

Table 3. Pearson correlations of abortion service indices for non-Catholic, nonfederal hospital abortion providers, Maryland, 1976 (N=29)

Abortion service index	Range	Institutionalization	Restrictiveness
No. of abortions	.51*	.72*	.00
Range of services		.51*	.00
Institutionalization of services			.10

*In this and subsequent tables, indicates significance at .05 level or greater.

Before these results are examined more closely, it is appropriate to evaluate the independent role of each of the control variables in determining the provision of hospital abortion services. The correlations of abortion need and of the hospital's organizational characteristics with the four indices of abortion services (number of abortions, and range, institutionalization and restrictiveness of services) are shown in Table 5.

Each of the control variables is strongly, significantly and positively associated with the number of abortions performed by Maryland hospitals in 1976, and with the range of abortion services these hospitals provide. Institutionalization of abortion services is correlated with need for abortion, with hospital size and with the number of medical departments, but not with medical school affiliation. The only control variable significantly associated with restrictiveness of services is the number of medical departments.*

In summary, both the attitudinal variables and the control variables (need for abortion in the county where the hospital is located and hospital organizational characteristics) are consistently associated with at least two of the four indices of hospital abortion performance employed in this study: number of abortions performed and range of abortion services.

The final steps in this analysis are to examine the relative contribution of the attitudinal and the control variables to hospitals' abortion activities, as defined by these two indices, and to determine the combined ability of these variables to account for differences among hospitals in abortion performance. The analytic method employed for this purpose is ordinary least squares regression.

In the first regression analysis, need for abortion services, hospital size, number of medical departments and obstetricians' abortion-related attitudes are employed as predictors of the number of hospital abortions performed. The results of this analysis are described in Table 6. Column 1 of this table gives the standardized coefficients (weights) for each independent variable. Each of these weights represents the relative influence on abortions performed that is exerted by the corresponding independent variable *when all of the other independent variables in the analysis are held constant.* In more technical terms, column 1 shows how much change in the standard deviation of the dependent variable (number of abortions performed) is associated with a change of *one* standard deviation in a given independent variable. The effect of each independent variable can be expressed in more readily understandable terms using unstandardized, or metric, coefficients. The metric coefficients from the analysis shown in Table 6 cannot, however, be employed directly,

Table 4. Pearson correlations of obstetricians' attitudes with abortion service indices for non-Catholic, nonfederal hospitals, Maryland, 1976

Abortion service index	Favor expansion of fertility-related services	Frequently disturbed by participation in abortion procedures
No. of abortions	.36*	-.45*
(N†)	(34)	(30)
Range of services	-.16	-.37*
(N‡)	(29)	(27)
Institutionalization of services	.12	-.21
(N‡)	(29)	(27)
Restrictiveness	-.23	.13
(N‡)	(29)	(27)

†N is less than 40 due to missing data on attitudinal dimensions.

‡Includes *only* non-Catholic, nonfederal hospitals that performed abortions in 1976. N is less than 30 due to missing data.

*More detailed analysis indicates that the association between number of medical departments and restrictiveness is independent of medical school affiliation. Furthermore (as noted earlier), there is no relationship between the presence of restrictions and the number of abortions performed by those hospitals that do any abortions. These data support the suggestion that in hospitals that perform abortions, restrictions are primarily a function of bureaucratization.

because of the data transformations described in the second footnote on page 28. Analysis using untransformed (raw) measures of need, hospital size and number of abortions demonstrates that an increase in hospital size of one bed is associated with 1.8 additional abortions per year, while an increase of one scale point in average favorableness of doctor attitudes toward expansion of fertility-related services increases the annual number of a hospital's abortions by 142. The latter effect appears to be substantial. However, it is, in fact, an underestimate of the actual effect of fertility attitudes.* The cumulative variance accounted for by each independent variable is shown in column 2.

The need for abortion services in the hospital community is essentially unrelated to the number of abortions performed by non-Catholic, nonfederal hospitals in Maryland, once other variables have been controlled. (Indeed, the failure of hospitals to respond to abortion need in their communities has been cited as a major reason for the phenomenal growth of nonhospital abortion clinics.[17]) The degree of specialization, as indicated by the number of medical departments, also does not hold up as a predictor when the effects of other variables in the analysis are taken into account (although number of departments is an important variable theoretically, and is significantly correlated with abortion performance in bivariate analysis). Of the remaining variables, the one most important in explaining the low independent predictive value of need and number of departments is hospital size. Large hospitals are located in communities with high need and tend to have many departments. The high correlations of these last two variables with size, and the very substantial association between size and number of abortions performed (the bivariate correlation coefficient was .73), largely account for the disappearance of need and number of departments as important predictors once hospital size is controlled. Size, on the other hand, has a large independent effect on the number of abortions, as Table 6 shows: There are more abortions in larger hospitals.

Initially, we hypothesized that the abortion-related attitudes of private obstetrician-gynecologists affiliated with a particular hospital would be independently associated with that hospital's abortion performance, once local need for abortion and relevant characteristics of hospital organization had been controlled. This hypothesis, insofar as it applies to the *number* of abortions performed, is supported by the data presented in Table 6. Both physicians' attitudes toward the expansion of fertility-related services and their degree of disturbance at abortion procedures are independently and significantly related to the number of abortions performed in the hospital. It should be emphasized that physicians' *personal psychological reaction* to abortion is related to the number of abortions performed in the hospital, independent of hospital policy favorable to the provision of abortion and contraceptive services. In an earlier article, we noted the independent impact of psychological response to abortion on obstetricians' management of private abortion patients.[18] Here, we see a parallel impact on the number of abortions done in private, non-Catholic hospitals.

Column 2 of Table 6 presents data showing the cumulative variance (r^2) explained by each independent variable *after* accounting for all *prior* variables. For this analysis, independent variables were entered into the equation in the order in which they are listed in Table 6, starting with need for abortion in the hospital community. Need, in other words, was allowed to account for the maximum variance, *without* controls. Hospital size was entered next, adding 24 percent to the variance explained after accounting for need. The third variable added to the equation was number of medical departments; once hospital size and need are accounted for, this variable adds very little to the equation's explanatory power. The two measures of obstetricians' attitudes were the last variables to be added. This procedure represents the most stringent test of the hypothesis that obstetricians' attitudes are associated with hospital abortion performance, since it allows the maximum possible variance in performance to be explained by the control variables, before the effects of the attitudinal variables are examined. Together, the attitudinal variables add 15 percent to the variance explained; bringing the total variance explained to 73 percent.

The results of the second multiple-regression analysis, for *range* of abortion services provided by hospitals in which *any* abortions were performed in 1976, are presented in Table 7. The independent variables (predictors) in this analysis are the same as those employed in Table 6, except that medical school affiliation rather than number of medical departments is used as

Table 5. Pearson correlations of abortion need and hospital organizational characteristics with abortion service indices for non-Catholic, nonfederal hospitals, Maryland, 1976

Abortion service index	Abortion need	Hospital size	Medical school affiliation	No. of medical depts.
No. of abortions (N†)	.58* (39)	.73* (39)	.59* (39)	.46* (38)
Range of services (N‡)	.66* (29)	.54* (29)	.61* (29)	.37* (29)
Institutionalization of services (N‡)	.42* (29)	.47* (29)	.18 (29)	.31* (29)
Restrictiveness (N‡)	.07 (29)	.10 (29)	.08 (29)	.40* (29)

†N is less than 40 due to missing data.

‡Includes *only* non-Catholic, nonfederal hospitals that performed abortions in 1976. N is less than 30 due to missing data.

*Transformation of certain variables, as described earlier, was necessary in order to correct for the skewness that produced this underestimation.

†In multiple-regression analyses (not shown) using six independent variables (including both organizational indices), the number of medical departments was the better of the two organizational variables in predicting the number of abortions performed, while medical school affiliation performed better as a predictor of the range of services. Given the relatively small number of hospitals included in these analyses (30 for number of abortions, 28 for range of services), it was felt desirable to limit the number of predictors to five. Consequently, for each of the two analyses reported, the better predictor of the two organizational indices was selected.

Table 6. Multiple regression analysis of number of abortions performed by non-Catholic, nonfederal hospitals, Maryland, 1976 (N=30)

Independent variable†	No. of abortions	
	Stand. coeff.	Cum. variance explained (r^2)
Abortion need	−.04	.33
Hospital size	.62*	.57
No. of medical depts.	.14	.58
Fertility-service attitude	.33*	.69
Disturbance by abortion	−.25*	.73
Total r^2		.73

†Specification of measures for independent variables—abortion need: estimate of annual need for abortion in county where hospital is located (square root); hospital size: number of beds (square root); fertility-service attitudes: five-point scale measuring attitudes toward expansion and liberalization of abortion and contraceptive services (1 = conservative, 5 = liberal); frequency of disturbance: four-point scale indicating how frequently MD is "disturbed" by abortion (1 = never disturbed; 4 = often disturbed).

an indicator of hospital organization.† The pattern of regression results for range of services offered is considerably different from that for number of abortions performed. Obstetricians' attitudes are not statistically significant at the .05 level; need for abortion in the community is now the dominant variable. Medical school affiliation is also an important predictor of range of services offered, although its contribution does not quite reach statistical significance. Together, all of the predictors are able to explain 56 percent of the variation in range of services provided by Maryland hospitals where abortions are performed.

Discussion

Studies of hospitals have tended to emphasize structural characteristics of the hospitals' local environment and internal organization rather than individual attitudes and values as determinants of adoption of innovations. The findings presented here indicate, however, that there are conditions under which individual attitudes have a significant influence on innovation. While dimensions of abortion services likely to be under administrative rather than physician control (e.g., the range of abortion-related services offered within the hospital setting) were found to be associated with the classical structural variables, attitudes of staff obstetricians turned out to be of major importance in accounting for the volume of abortions performed. These latter results appear to be due to unique characteristics of abortion as a hospital service.

In a separate investigation, it was shown that relative to other recent innovations in obstetrics, abortion services are perceived by obstetrician-gynecologists as carrying the highest risk of arousing opposition from within the hospital and of threatening the hospital's reputation in its community.* Thus, it is not surprising to find that the level at which these services are provided is strongly influenced by personal conviction regarding their value and by their psychological acceptability to the physician. In the majority of hospitals studied abortions are carried out by private-physician members of the medical staff. Unless there is a major institutional commitment to provision of abortion services (as in certain teaching hospitals) or to prohibition of these services (as in Catholic hospitals), it is the attitudes and beliefs of these individual private physicians that ultimately determine the hospital's role in providing abortion services. When these personal feelings are unfavorable, the perceived social risk attached to abortion services will be sufficient to prevent them from being offered or to ensure that few abortions are performed.

Although staff obstetricians' attitudes were found to be an important variable in accounting for the *number* of abortions hospitals performed, the hypothesis that those attitudes would be associated with the range of abortion-related services offered and with policy restrictions on access to abortion was not supported.† As suggested above, it may be that these dimensions of hospital abortion practice are under primarily administrative rather than physician control, and are consequently less responsive to variations in physicians' attitudes. The importance of need for abortion in the hospital community as a predictor of the *range* of abortion services offered but not of the number of abortions provided is of interest, since prior research has largely discounted need as a major determinant of hospital services.[19] However, additonal data would be required to interpret the meaning of this relationship.

The delivery of abortion services by freestanding abortion clinics outside the mainstream of American medicine has aroused concern among some public health workers,[20] and the failure of non-Catholic hospitals to meet what are felt to be their responsibilities in this area has been deplored.[2]

Hospitals may continue to refuse to offer abortion services if doctor support does not grow.

Table 7. Multiple regression analysis of range of abortion-related services provided by non-Catholic, nonfederal hospitals performing abortions, Maryland, 1976 (N=29)

Independent variable †	Range of services	
	Stand. coeff.	Cum. variance explained (r^2)
Abortion need	.49	.44
Hospital size	−.06	.47
Medical school affiliation	.36	.52
Fertility-service attitude	.22	.56
Disturbance by abortion	.05	.56
Total r^2		.56

†Specification of measures for independent variables is the same as in Table 6, except for medical school affiliation: affiliation as reported by American Hospital Association (1=no affiliation, 2=affiliation).

*As part of a study of hospital innovations in maternal health care carried out by one of us (Nathanson), a panel of seven board-certified obstetrician-gynecologists engaged in teaching, research and practice were asked to rate 20 recent inocvations in obstetrical programs and services ranging from amniocentesis and fetal monitoring to adolescent pregnancy clinics and nurse-midwifery. Abortion services were rated highest among the 20 on two dimensions: "may, in some cases, be opposed by individuals or groups within the hospital"; if adopted, might threaten the reputation of the hospital in the community."

†Multiple-regression analyses (not shown) of the institutionalization and restrictiveness scales, using the same set of predictors employed in Table 6, showed no significant independent effects of either attitudinal variable on these service indices, nor did the effects of any control variables reach statistical significance.

These data imply that the explanation for these phenomena goes beyond resource availability and organizational capacity, and that, short of major changes in physicians' support and acceptance of legal abortion, physicians' attitudes will continue to limit the availability of abortion as a hospital service.

References

1. J.D. Forrest, E. Sullivan and C. Tietze, *Abortion 1976-1977: Need & Services in the United States, Each State & Metropolitan Area*, The Alan Guttmacher Institute (AGI), New York, 1979, Table 25.

2. Ibid., Table E; and AGI, *Provisional Estimates of Abortion Need & Services in the Year Following the 1973 Supreme Court Decisions: United States, Each State & Metropolitan Area*, New York, 1975, Table 5.

3. E.M. Gold, C.L. Erhardt, H. Jacobziner and F.G. Nelson, "Therapeutic Abortions in New York City: A 20-Year Review," *American Journal of Public Health*, 55:964, 1965; R.E. Hall, "Therapeutic Abortion, Sterilization and Contraception," *American Journal of Obstetrics and Gynecology*, 91:518, 1965; C.L. Erhardt, C. Tietze and F.G. Nelson, "United States: Therapeutic Abortions in New York City," *Studies in Family Planning*, Vol. 1, No. 51, 1970, p. 8; R.E. Hall, "Abortion: Physician and Hospital Attitudes," *American Journal of Public Health*, 61:517, 1971; J.H. Knowles, "The Health System and the Supreme Court Decision: An Affirmative Response," *Family Planning Perspectives*, 5:113, 1973; and R. Roemer, "Equity in Abortion Services," *American Journal of Public Health*, 68:629, 1978.

4. R.E. Hall, 1971, op. cit.; and J. Miller, "The Response of New York State Hospitals to the Legalization of Abortion Services: An Analysis of Program Innovation," paper presented at the annual meeting of the American Sociological Association, New York, Aug. 1976.

5. E.M. Rogers and F.F. Shoemaker, *Communication of Innovations*, Free Press, New York, 1971.

6. M.M. Rosner, "Economic Determinants of Organizational Innovation," *Administrative Science Quarterly*, 12:614, 1965; A.D. Kaluzny, J.H. Glasser, J.T. Gentry and J. Sprague, "Diffusion of Health Care Innovations in the United States: A Study of Hospitals," *Medical Care*, 8:474, 1970; J.E. Veney, A.D. Kaluzny, J.T. Gentry, J.B. Sprague and D.P. Duncan, "Implementation of Health Programs in Hospitals," *Health Services Research*, 6:350, 1971; J.E. Veney and J. Kahn, "Causal Paths in Elaboration of Organizational Structure: A Case of Hospital Services," *Health Services Research*, 8:139, 1973; A.D. Kaluzny, J.E. Veney and J.T. Gentry, "Innovation of Health Services: A Comparative Study of Hospitals and Health Departments," *Milbank Memorial Fund Quarterly/Health and Society*, 52:51, 1974; M.K. Moch and E.V. Morse, "Size, Centralization and Adoption of Innovations," *American Sociological Review*, 42:716, 1977; and J.R. Kimberly, "Hospital Adoption of Innovation: The Role of Integration into External Informational Environments," *Journal of Health and Social Behavior*, 19:361, 1978.

7. C.A. Nathanson and L.L. Morlock, "Control Structure, Values and Innovation: A Comparative Study of Hospitals," paper presented at the annual meeting of the American Sociological Association, San Francisco, Sept. 5, 1978.

8. Ibid.

9. C.A. Nathanson and M.H. Becker, "The Influence of Physicians' Attitudes on Abortion Performance, Patient Management and Professional Fees," *Family Planning Perspectives*, 9:158, 1977; and C.A. Nathanson and M.H. Becker, "Physician Behavior as a Determinant of Utilization Patterns: The Case of Abortion," *American Journal of Public Health*, 68:1104, 1978.

10. Earlier results of this survey were reported in C.A. Nathanson and M.H. Becker, 1977, op. cit., and 1978, op. cit.

11. J.E. Veney and J. Kahn, 1973, op. cit.; A.D. Kaluzny et al., 1974, op. cit.; and M.K. Moch and E.V. Morse, 1977, op. cit.

12. J.Q. Wilson, "Innovation in Organization: Notes Toward a Theory," in J.D. Thompson, ed., *Approaches to Organizational Design*, University of Pittsburgh Press, Pittsburgh, 1966; and M.K. Moch and E.V. Morse, 1977, op. cit.

13. C.A. Nathanson and L.L. Morlock, 1978, op. cit.

14. American Hospital Association, *Guide to the Health Care Field*, Chicago, 1977.

15. R.C. Lerner, J. Bruce, J. Ochs, S. Wassertheil-Smoller and C. Arnold, "Abortion Programs in New York City: Services, Policies, and Potential Health Hazards," *Milbank Memorial Fund Quarterly/Health and Society*, 52:15, 1974.

16. C.A. Nathanson and M.H. Becker, 1977, op. cit.

17. AGI, *Abortion 1974–1975: Need & Services in the United States, Each State & Metropolitan Area*, New York, 1976.

18. C.A. Nathanson and M.H. Becker, 1977, op. cit.

19. D.B. Smith and A.D. Kaluzny, "Inequality in Health Care Programs: A Note on Some Structural Factors Affecting Health Care Behavior," *Medical Care*, 13:860, 1974.

20. E. Sullivan, C. Tietze and J.G. Dryfoos, "Legal Abortion in the United States, 1975–1976," *Family Planning Perspectives*, 9:116, 1977.

21. AGI, 1976, op. cit.

Document #11

hospital mortality

PAS hospitals

united states, 1974-75

Commission on Professional and Hospital Activities
Ann Arbor, Michigan
March 1977

Table D

Rankings* of Operation Groups by Fatality Rate, Number of Patients, and Number of Deaths**

Ranking by Fatality Rate (1)		Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
1	456	Operations on larynx and trachea except excision and permanent tracheostomy	3,899	23,147	125	9,024	4
2	455	Permanent tracheostomy	2,486	1,239	219	308	77
3	476	Gastrostomy	2,324	5,520	194	1,283	40
4	401	Craniotomy	2,311	24,491	117	5,659	8
5	461	Thoracentesis	1,910	48,023	64	9,170	3
6	599	Above-knee amputation	1,677	15,796	158	2,649	21
7	486	Ileostomy, colostomy, other enterostomy	1,668	17,670	151	2,947	17
8	472	Bone marrow transplant	1,579	57	225	9	196
9	402	Incision, excision of skull, brain, and cerebral meninges	1,575	16,493	156	2,598	23
10	478	Complete gastrectomy	1,510	2,205	215	333	74
11	620	Miscellaneous nonsurgical procedures	1,457	15,329	159	2,234	27

*Factors used to determine rankings were as follows:
1. Rankings by fatality rate—primary factor: fatality rate. In case of ties, secondary factors: number of patients, and operation group number.
2. Rankings by number of patients—primary factor: number of patients. In case of ties, secondary factor: operation group number
3. Rankings by number of deaths—primary factor: number of deaths. In case of ties, secondary factor, ranking by fatality rate.

** Groups are displayed in descending order by fatality rate. The group with the largest fatality rate is assigned rank 1.

Table D (Continued)

Ranking by Fatality Rate (1)		Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranki by Numb Deat (7)
12	621	Peritoneal dialysis	1,383	13,192	173	1,825	33
13	482	Resection of small intestine	1,339	18,622	148	2,494	24
14	499	Operations on pancreas	1,299	5,472	195	711	55
15	467	Extracorporeal cardiopulmonary bypass	1,294	680	222	88	125
16	505	Incision, excision of abdominal wall and peritoneum	1,156	130,511	26	15,092	1
17	496	Miscellaneous operations on liver	1,067	29,362	107	3,133	15
18	464	Pacemaker implantation and miscellaneous operations on heart	1,045	65,654	46	6,861	6
19	468	Operations on blood vessels except vein ligation and bypass	1,004	105,344	32	10,576	2
20	484	Other incision, excision of intestine	983	8,636	185	849	49
21	598	Below-knee amputation	839	14,154	167	1,187	44
22	462	Operations on chest wall, pleura, and mediastinum except thoracentesis	820	65,580	47	5,378	10
23	463	Operations on heart, pericardium, and heart vessels	797	60,818	55	4,845	11
24	498	Operations on biliary tract and gallbladder except cholecystectomy	797	21,608	131	1,723	35
25	596	Amputation of hand, forearm, and upper arm	723	1,549	218	112	115
26	459	Lobectomy and total pneumonectomy	718	17,012	155	1,221	41

Table D (Continued)

Ranking by Fatality Rate (1)	Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
27	405 Miscellaneous operations on brain and cerebral meninges	673	5,866	192	395	68
28	457 Incision and excision of lesion of bronchus	671	17,125	152	1,149	45
29	458 Bronchial resection and miscellaneous operations on bronchus	667	345	223	23	167
30	466 Systemic shunt or graft bypass	664	44,759	72	2,973	16
31	404 Ventricular shunt	658	4,956	197	326	75
32	600 Other amputation of lower extremity	656	2,423	214	159	101
33	483 Colectomy	645	85,916	36	5,544	9
34	587 Other arthroplasty and reconstruction of hip	641	44,111	75	2,826	20
35	477 Partial gastrectomy	635	44,587	74	2,833	19
36	473 Miscellaneous operations on spleen and bone marrow	633	18,954	145	1,199	43
37	626 Arteriography of head and neck	621	119,222	30	7,400	5
38	460 Miscellaneous operations on lung	595	38,408	90	2,285	26
39	510 Ureteral diversion	565	2,657	212	150	103
40	485 Anastomosis, repair of intestine	546	39,605	87	2,161	28
41	474 Operations on esophagus	544	32,061	99	1,743	34
42	495 Incision of liver	466	40,829	81	1,904	31
43	480 Miscellaneous operations on stomach	464	53,566	63	2,488	25
44	414 Operations on endocrine glands except parathyroid and thyroid	461	3,795	205	175	94

Table D (Continued)

Ranking by Fatality Rate (1)	Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
45	490 Proctectomy	452	19,462	143	879	47
46	615 Bronchoscopy	402	83,925	37	3,375	14
47	507 Total nephrectomy	388	20,489	136	795	53
48	506 Miscellaneous operations on abdominal wall and peritoneum	361	40,368	83	1,458	37
49	403 Cranioplasty	357	7,619	186	272	81
50	521 Miscellaneous operations on urinary tract	340	1,000	221	34	154
51	469 Incision, excision of lymph nodes	327	62,393	51	2,039	29
52	475 Gastrotomy, pyloromyotomy	327	8,861	184	290	80
53	513 Miscellaneous operations on bladder	311	41,361	79	1,285	39
54	454 Complete laryngectomy	287	3,419	209	98	120
55	576 Open reduction of fracture except maxillofacial	283	225,670	11	6,394	7
56	410 Sympathectomy	283	13,271	172	375	69
57	407 Operations on spinal cord structures except exploration	265	22,162	129	588	61
58	479 Vagotomy	263	20,362	138	535	65
59	623 Encephalography and ventriculography	254	23,746	122	604	59
60	406 Exploration of spinal cord structures	219	28,946	108	635	58
61	470 Radical lymphadenectomy	208	12,589	175	262	82
62	481 Local excision of intestinal lesion	207	38,447	89	796	52
63	491 Miscellaneous operations on rectum	194	6,187	189	120	113

Table D (Continued)

Ranking by Fatality Rate (1)	Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
64	628 Venography, angiography, and other arteriography	193	74,993	42	1,445	38
65	504 Repair of diaphragmatic and other hernia	192	18,636	147	357	71
66	616 Esophagoscopy and gastroscopy	186	155,758	21	2,900	18
67	597 Amputation of toes	185	15,888	157	294	78
68	411 Miscellaneous operations on sympathetic nerves and ganglia	176	3,464	207	61	134
69	508 Miscellaneous operations on kidney	162	43,359	77	703	56
70	627 Aortography and angiocardiography	156	77,325	40	1,204	42
71	573 Repair and plastic operation on bone except facial	155	22,989	126	356	72
72	523 Other prostatectomy	153	42,542	78	653	57
73	619 Cardiac catheterization	152	120,344	29	1,830	32
74	586 Total hip replacement	144	41,052	80	590	60
75	520 Ureteral catheterization	138	9,647	181	133	111
76	489 Incision, excision of rectal and perirectal tissue	137	63,210	49	868	48
77	545 Radical hysterectomy and pelvic exenteration	135	3,841	204	52	138
78	524 Miscellaneous operations on prostate and seminal vesicle	123	14,975	161	184	92

Table D (Continued)

Ranking by Fatality Rate (1)	Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
79	625 Miscellaneous radiography except arteriography, venography, and angiography	121	81,922	38	991	46
80	578 Open reduction of dislocation	116	10,120	179	117	114
81	601 Revision of amputation stump	116	5,933	191	69	131
82	512 Transurethral excision of bladder lesion	101	80,341	39	808	51
83	526 Orchiectomy	101	21,243	135	214	87
84	522 Transurethral prostatectomy	99	201,007	15	1,985	30
85	497 Cholecystectomy	98	368,936	6	3,612	13
86	448 Operations on tongue, oral cavity, and facial region except frenotomy and palatoplasty	98	22,644	128	223	85
87	609 Other incision, excision, and suture of skin	93	512,582	2	4,742	12
88	488 Operations on appendix except appendectomy	93	3,449	208	32	156
89	452 Operations on pharynx except tonsillectomy and adenoidectomy	92	20,460	137	189	91
90	471 Miscellaneous operations on lymphatic system	90	222	224	2	221
91	534 Bilateral oophorectomy or salpingo-oophorectomy	89	21,791	130	195	90

Table D (Continued)

Ranking by Fatality Rate (1)	Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
92	617 Cystoscopy and urethroscopy	82	317,625	8	2,604	22
93	554 Vulvectomy	74	2,836	211	21	172
94	575 Closed reduction of fracture except maxillofacial	73	205,631	14	1,499	36
95	614 Endoscopy with surgical approach	71	43,603	76	310	76
96	604 Complete mastectomy	69	19,660	141	135	109
97	610 Free skin grafts	66	38,127	93	251	83
98	572 Excision of bone except facial	65	117,830	31	771	54
99	531 Miscellaneous operations on penis	64	14,254	165	91	123
100	579 Arthrocentesis and injection into joint	61	27,195	112	167	97
101	503 Repair of other anterior abdominal wall hernia	58	62,360	52	363	70
102	568 Repair and plastic operations on facial bones	58	6,689	188	39	147
103	567 Excision of facial bone	56	4,783	198	27	162
104	439 Miscellaneous operations on nose	53	45,918	66	245	84
105	577 Closed reduction of dislocation	51	19,497	142	100	119
106	552 Miscellaneous operations on vagina	47	34,368	95	163	100
107	525 Operations on scrotum and tunica vaginalis	47	13,802	169	65	133
108	570 Incision and division of bone	45	30,813	104	139	107
109	429 Operations on orbit and eyeball	45	17,072	153	77	128

Table D (Continued)

Ranking by Fatality Rate (1)	Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
110	413 Operations on parathyroid and thyroid except thyroidectomy	45	9,076	183	41	143
111	502 Repair of umbilical hernia	44	44,812	71	199	89
112	584 Spinal fusion	44	21,290	134	93	122
113	611 Pedicle graft of skin	42	9,573	182	40	146
114	516 Urethral dilation	41	135,119	25	552	62
115	509 Ureterotomy	40	23,635	123	94	121
116	453 Excision of lesion of larynx and trachea, partial laryngectomy	39	44,611	73	175	95
117	532 Excision of lesion of ovary	39	38,178	92	147	104
118	589 Incision and division of muscle, tendon, fascia, and bursa	34	21,370	133	73	129
119	441 Miscellaneous operations on accessory sinus	34	12,755	174	44	142
120	624 Myelography	33	166,080	19	541	64
121	542 Hysterotomy and excision of lesion of uterus	33	12,549	176	41	144
122	574 Removal of internal fixation device	32	57,275	57	182	93
123	533 Unilateral oophorectomy or salpingo-oophorectomy	30	45,873	67	137	108
124	417 Miscellaneous operations on eyelid	28	38,824	88	110	116
125	446 Operations on salivary glands and ducts	28	25,140	116	70	130

Table D (Continued)

Ranking by Fatality Rate (1)		Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
126	566	Open reduction of maxillofacial fractures	28	24,415	118	68	132
127	412	Thyroidectomy	27	61,793	54	166	98
128	420	Operations on conjunctiva	27	3,329	210	9	197
129	540	Other excision of cervix	26	62,295	53	165	99
130	511	Miscellaneous operations on ureter	26	40,759	82	108	118
131	605	Radical mastectomy	25	69,290	43	173	96
132	569	Miscellaneous maxillofacial surgery	25	1,621	217	4	211
133	590	Excision of lesion of muscle, tendon, fascia, and bursa	24	89,355	34	211	88
134	494	Miscellaneous operations on anus	24	46,256	65	110	117
135	517	Miscellaneous operations on urethra	24	32,643	98	78	127
136	487	Appendectomy	23	243,453	10	549	63
137	580	Arthrotomy and division of joint capsule	23	57,039	58	134	110
138	430	Operations on external ear	22	24,077	121	54	137
139	444	Operations on teeth and gums except extraction and restoration	22	14,140	168	31	158
140	500	Unilateral repair of inguinal or femoral hernia	21	397,577	5	833	50
141	581	Excision of intervertebral disc	21	138,107	24	291	79
142	519	Other repair of stress incontinence	21	1,928	216	4	212
143	588	Repair of other joint	19	76,125	41	146	105
144	602	Reattachment of extremity	19	1,067	220	2	222

Table D (Continued)

Ranking by Fatality Rate (1)		Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
145	565	Closed reduction of maxillofacial fractures	18	18,110	150	32	157
146	612	Plastic operation on lip and external mouth	18	10,541	177	19	174
147	535	Miscellaneous operations on ovary	18	4,426	200	8	201
148	595	Amputation of finger and thumb	17	19,684	140	34	155
149	438	Other incision, excision of nose	16	32,039	100	50	139
150	560	Other cesarean section	16	30,360	106	48	140
151	435	Miscellaneous operations on middle ear and inner ear	16	14,549	164	24	166
152	555	Miscellaneous operations on vulva and perineum	16	4,354	201	7	205
153	501	Bilateral repair of inguinal or femoral hernia	15	54,492	61	84	126
154	492	Excision of anal lesion	15	27,250	111	41	145
155	583	Miscellaneous excision of joint structures	15	24,375	119	36	152
156	528	Interruption of vas deferens	14	18,375	149	25	164
157	440	Radical maxillary sinusotomy	14	13,493	171	19	175
158	606	Incision and excision of breast except mastectomy	13	333,444	7	446	67
159	553	Incision and excision of lesion of vulva and perineum	13	44,971	70	60	135
160	515	Excision of lesion, repair of urethra	13	30,534	105	39	148
161	423	Operations on sclera, anterior chamber, iris, and ciliary body	13	28,421	110	38	150

Table D (Continued)

Ranking by Fatality Rate (1)		Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
162	447	Palatoplasty	13	5,338	196	7	206
163	543	Abdominal hysterectomy	12	429,131	4	517	66
164	424	Intracapsular lens extraction	12	280,382	9	336	73
165	425	Other lens extraction	12	25,846	114	31	159
166	514	Urethral meatotomy	11	27,034	113	30	160
167	408	Excision of lesion of peripheral nerve	11	21,465	132	23	168
168	551	Other colporrhaphy	10	13,508	170	14	186
169	428	Miscellaneous operations on retina, choroid, and vitreous	10	3,850	203	4	213
170	409	Miscellaneous operations on cranial and other peripheral nerves	9	65,998	45	58	136
171	593	Resection and suture of muscle, tendon, and fascia except hand	9	40,130	84	38	151
172	613	Miscellaneous operations on skin and subcutaneous tissue	9	28,521	109	26	163
173	427	Repair of retina	9	23,584	124	22	170
174	549	Miscellaneous operations on uterus, cervix, and supporting structures	9	14,581	162	13	188
175	415	Operations on lacrimal apparatus	9	5,538	193	5	209
176	442	Tooth extraction	8	198,320	16	154	102
177	493	Hemorrhoidectomy	8	159,490	20	122	112
178	607	Miscellaneous operations on breast	8	31,532	103	25	165

Table D (Continued)

Ranking by Fatality Rate (1)		Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
179	518	Urethral suspension	8	19,257	144	16	180
180	442	Tooth restoration and orthodontia	8	14,571	163	12	189
181	603	Miscellaneous operations on musculoskeletal system	8	14,248	166	11	191
182	445	Frenotomy	8	3,768	206	3	214
183	530	Circumcision	7	69,078	44	48	141
184	538	Miscellaneous operations on fallopian tube	7	31,551	102	23	169
185	591	Division and resection of muscle, tendon, and fascia of hand	7	22,906	127	16	181
186	422	Miscellaneous operations on cornea	7	14,982	160	10	193
187	563	Intra-uterine procedures on fetus	7	10,008	180	7	207
188	421	Corneal transplant	7	4,061	202	3	215
189	559	Low cervical cesarean section	6	218,532	12	140	106
190	539	Conization of cervix	6	34,866	94	22	171
191	527	Miscellaneous operations on testis	6	24,253	120	15	185
192	416	Excision of lesion of eyelid	6	17,027	154	11	192
193	544	Vaginal hysterectomy	5	191,950	17	91	124
194	550	Plastic repair of cystocele and rectocele	5	54,487	62	29	161
195	529	Miscellaneous operations on spermatic cord, epididymis, and vas deferens	5	40,014	86	19	176
196	594	Operations on muscle, tendon, fascia, and bursa except hand	5	31,962	101	16	182

Table D (Continued)

Ranking by Fatality Rate (1)	Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
197	434 Mastoidectomy	5	18,773	146	10	194
198	548 Repair and plastic operations on supporting structures of uterus	5	6,112	190	3	216
199	465 Ligation and stripping of veins	4	87,599	35	39	149
200	585 Arthrodesis and stabilization of joint	4	25,594	115	9	198
201	426 Miscellaneous operations on lens	4	6,807	187	3	217
202	419 Miscellaneous operations on ocular muscle	4	2,556	213	1	224
203	582 Excision of semilunar cartilage of knee joint	3	127,373	27	36	153
204	433 Myringotomy	3	62,636	50	16	183
205	546 Dilation and curettage of uterus	2	891,470	1	221	86
206	437 Rhinoplasty	2	93,404	33	21	173
207	608 Incision and excision of pilonidal sinus	2	56,589	60	12	190
208	436 Submucous resection of nasal septum	2	45,007	69	9	199
209	571 Bunionectomy	2	40,100	85	9	200
210	561 Intra-amniotic injection	2	38,336	91	8	202
211	592 Repair and plastic operations on hand	2	33,136	96	8	203
212	557 Breech extraction	2	32,800	97	8	204
213	431 Stapedectomy	2	19,733	139	3	218
214	541 Repair and plastic operations on cervix and uterus	2	10,200	178	2	223
215	562 Diagnostic amniocentesis	2	4,721	199	1	225
216	449 Tonsillectomy without adenoidectomy	1	208,568	13	19	177

Table D (Continued)

Ranking by Fatality Rate (1)	Operation Group (2)	Fatality Rate per 10,000 Patients (3)	Number Patients (4)	Ranking by Number Patients (5)	Number Deaths (6)	Ranking by Number Deaths (7)
217	537 Other bilateral tubal interruption or salpingectomy	1	187,615	18	18	179
218	536 Endoscopic bilateral interruption of tubes	1	145,546	22	14	187
219	564 Miscellaneous obstetric procedures	1	139,420	23	19	178
220	547 Aspiration curettage of uterus	1	124,283	28	10	195
221	558 Other assisted delivery except low forceps and episiotomy	1	63,466	48	7	208
222	418 Resection and recession of ocular muscle	1	60,401	56	5	210
223	451 Adenoidectomy without tonsillectomy	1	56,704	59	3	219
224	432 Tympanoplasty	1	45,283	68	3	220
225	450 Tonsillectomy with adenoidectomy	<1	458,688	3	16	184

Document #12

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Methods of Midtrimester Abortion: Which Is Safest?

David A. Grimes, Kenneth F. Schulz, Willard Cates, Jr., and Carl W. Tyler, Jr.
U. S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Bureau of Epidemiology, Family Planning Evaluation Division, Atlanta, Georgia, USA

ABSTRACT

Grimes, D. A., Schulz, K. F., Cates, W., Jr. and Tyler, C. W., Jr. (U. S. Dept. of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Bureau of Epidemiology, Family Planning Evaluation Division, Atlanta, Georgia, USA). *Methods of midtrimester abortion: which is safest? Int J Gynaecol Obstet 15: 184-188, 1977*

In the United States, the three principal methods of abortion for patients at 13 or more menstrual weeks' gestation are intraamniotic instillation of saline or prostaglandin $F_{2\alpha}$ ($PGF_{2\alpha}$) and dilatation and evacuation (D&E). The relative safety of these methods, however, has not been established. This report compares the three methods using data on 17467 abortions collected by the Joint Program for the Study of Abortion under the auspices of the Center for Disease Control (JPSA/CDC). Abortion by D&E was found to be significantly safer than abortion by saline instillation ($p<0.001$), and abortion by saline instillation was significantly safer than by $PGF_{2\alpha}$ ($p<0.01$). Moreover, midtrimester D&E is both safe and practical; it is a direct and rapid procedure which can be performed on an outpatient basis. Although $PGF_{2\alpha}$ accelerated the time required for abortion, it also significantly increased serious morbidity.

INTRODUCTION

In 1974, 88% of the more than 100000 legal midtrimester (13-24 menstrual weeks' gestation) abortions reported in the United States were performed by either the intraamniotic instillation of saline or prostaglandin $F_{2\alpha}$ ($PGF_{2\alpha}$) or by dilatation and evacuation (D&E) (5). Hence, the relative safety of these three methods of midtrimester abortion has major medical, social, and economic significance for American women. While it has been established that the risks of morbidity and mortality are greater for midtrimester than for first trimester abortion, the few comparative studies reported to date disagree on the relative safety of the three most widely used methods of midtrimester abortion.

In controlled trials of $PGF_{2\alpha}$ and saline instillation, patients aborted with $PGF_{2\alpha}$ had significantly higher rates of vomiting, diarrhea, hemorrhage, and incomplete abortion requiring surgical evacuation than did patients aborted with saline. However, $PGF_{2\alpha}$-treated patients had significantly lower rates of fever and shorter induction-to-abortion times than saline-treated patients (7, 17). In small, nonrandomized studies, $PGF_{2\alpha}$-treated patients had higher complication rates, including fever, hemorrhage, vomiting and diarrhea, and more frequently required surgical evacuation to complete the abortion. On the other hand, these patients had lower failure rates and shorter induction-to-abortion times (3, 9, 14). In summary, published reports concur that $PGF_{2\alpha}$ instillation produces abortion faster, but with higher incidences of gastrointestinal side effects. In spite of these observations, the overall safety of $PGF_{2\alpha}$ for midtrimester abortion has not been adequately evaluated.

Comparative data on the safety of midtrimester D&E are also scarce. One large observational study (16) reported that midtrimester D&E was safer than saline instillation at comparable gestational ages. Another smaller study concluded that it may be safer to abort patients at 13-15 weeks' gestation with D&E than to delay abortion until after the 15th week of pregnancy when saline instillation can be performed (4).

To compare the safety of the three principal methods of midtrimester abortion used in the United States, we analyzed data on 17467 midtrimester abortions performed by intraamniotic instillation of either saline or $PGF_{2\alpha}$ or by D&E. Our analysis is the first large-scale evaluation of these three methods using uniform definitions and classifications.

METHODS

The Joint Program for the Study of Abortion, conducted under the auspices of the Center for Disease Control (JPSA/CDC), is a prospective, multicenter study of the early medical complications of legally induced abortion. JPSA/CDC continues the investigation initiated by the Population Council in 1970 (16). From 1971 through 1975, 32 institutions provided CDC with 80437 detailed individual case reports on abortion

Table I. Rates and relative risks of intraamniotic prostaglandin $F_{2\alpha}$ versus saline for induction of abortion at 13-24 menstrual weeks' gestation

Complications and Treatment	Rate per 100 Abortions		Relative Risk[a]	95% Confidence Interval
	$PGF_{2\alpha}$	Saline		
Major complications	2.90	1.81	1.6	1.1-2.3
Fever ≥38°C for ≥1 day	10.80	4.99	2.2	1.8-2.6
Endometritis	3.46	2.43	1.4	1.0-2.0
Hemorrhage	5.80	1.86	3.1	2.4-4.0
Retained products of conception	36.10	28.27	1.3	1.2-1.4
Convulsions	0.32	0.08	4.0	1.3-12.2
Operative treatment of complications				
Laparotomy, hysterotomy, and hysterectomy	0.64	0.12	5.4	2.4-11.9
Curettage or manual evacuation of the uterus	41.34	32.80	1.3	1.2-1.4
Readmission to hospital	2.90	1.36	2.1	1.5-3.1

[a] *Rate of prostaglandin $F_{2\alpha}$ divided by rate of saline (with 95% confidence interval).*

morbidity. Trained abstractors at each institution transcribed information from patients' charts onto JPSA/CDC forms, which were then coded, keypunched, edited, and recorded on magnetic tape. For 94% of the patients, gestational age was calculated from the date of onset of the last menstrual period to the date of abortion; the physician's estimate of gestational age was used for 6% of the patients for whom one or both dates were unknown.

There were code designations for nearly 100 potential complications, ranging from vaginitis to death. From this list, 15 were selected as major: cardiac arrest; convulsions; death; endotoxic shock; fever for 3 or more days; hemorrhage necessitating blood transfusion; hypernatremia; injury to the bladder, ureter, or intestines; pelvic infection with 2 or more days of fever and a peak of at least 40°C or with hospitalization for 11 or more days; pneumonia; psychiatric hospitalization for 11 or more days; pulmonary embolism or infarction; thrombophlebitis; major surgical treatment of complications; and wound disruption after hysterotomy or hysterectomy.

The term "major complication rate" refers to the percentage of women sustaining 1 or more of these 15 complications. Differences in rates were compared by x^2 tests. Where specified, the ratios of rates (with 95% confidence intervals) were calculated by the method of Miettinen (11, 12).

COMPARISON OF ABORTION METHODS

Saline versus $PGF_{2\alpha}$

To compare the two chemical abortifacients, we reviewed reports of 1241 $PGF_{2\alpha}$ and 10013 saline abortions. Patients were from 13 to 24 menstrual weeks' gestation. Most women in both groups were young, white, unmarried, of low gravidity, and free of preexisting medical conditions. No concurrent surgery was performed for any of the patients. Abortifacients were administered via the intraamniotic route. The most common dose of $PGF_{2\alpha}$ was 40 mg, given to 44% of the patients aborted by instillation of $PGF_{2\alpha}$; the most common saline dose was 40 g (i.e., 200 cc of 20% saline) given to 77% of the patients aborted by saline instillation. The majority of patients in both groups received oxytocics, but very few received laminaria (none of the $PGF_{2\alpha}$ and only 4% of the saline abortion patients).

Saline was significantly safer for inducing abortion than $PGF_{2\alpha}$ (Table I). The major complication rates were 2.90 per 100 abortions for $PGF_{2\alpha}$ and 1.81 for saline ($p<0.01$). The relative risk of sustaining one or more major complications was 1.6 times higher for $PGF_{2\alpha}$-induced abortions than for saline abortions. Saline was safer than $PGF_{2\alpha}$ throughout the midtrimester. Standardized for gestational age, the relative risk of major complications for $PGF_{2\alpha}$-treated patients remained

1.6. The greater risk with $PGF_{2\alpha}$ was independent of patient age, patient follow-up, level of physician training, the presence of preexisting medical conditions, or the administration of prophylactic antibiotics.

When specific complications were compared, fever, endometritis, hemorrhage, retained products of conception, and convulsions were each significantly more frequent for $PGF_{2\alpha}$-treated patients ($p<0.05$). In addition, operative treatment of complications (including laparotomy, hysterotomy, and hysterectomy, as well as curettage or manual evacuation of the uterus) was required significantly more often ($p<0.001$) than after saline induction.

Lengths of hospital stay were similar for patients in both groups (mean, 2.1 days), although $PGF_{2\alpha}$ produced significantly shorter induction-to-abortion times: 24.8 versus 29.2 hours ($p<0.001$). On the other hand, patients receiving $PGF_{2\alpha}$ were significantly more likely to be readmitted to a hospital than those receiving saline ($p<0.001$).

D&E versus saline

Comparing D&E and intraamniotic saline instillation for inducing abortions at 13-20 weeks' gestation revealed even greater disparities in safety. Most of the 6213 D&E-treated and 8662 saline-treated patients were young, unmarried, primigravidas, and free of preexisting medical conditions. No concurrent surgery was performed in either group. D&E abortions used suction curettage, frequently in conjunction with crushing forceps or sharp curettage. Cervical dilatation was usually accomplished by using graduated metal dilators (92%) or laminaria (3%).

D&E was significantly safer than saline instillation at 13-20 weeks' gestation (Table II). The major complication rate for D&E-treated patients was 0.69 per 100 abortions; the corresponding rate for saline-treated patients was 1.78 ($p<0.001$).

The relative risk of sustaining one or more complications was 2.6 times higher for saline-treated than for D&E-treated patients. Standardized for gestational age, patient age, patient follow-up, preexisting conditions, prophylactic antibiotic administration, and level of training of the operator, D&E remained significantly safer than saline instillation ($p<0.001$).

Fever, endometritis, hemorrhage, retained products of conception, and urinary tract infection were each significantly more frequent among saline-treated patients, while cervical injury and uterine perforation were significantly more frequent among D&E-treated patients ($p<0.001$). Rates of uterine perforation, however, did not increase significantly with gestational age ($p>0.50$). D&E-treated patients required curettage or manual evacuation as treatment of a complication significantly less often than did saline-treated patients, although cervical suture as a treatment was significantly more frequent among D&E-treated patients ($p<0.001$). D&E patients spent significantly less time in hospital (mean, 0.2 days) than saline patients (mean, 2.1 days) ($p<0.001$). Readmission rates were not significantly different for the two groups ($p>0.10$.).

Table II. Rates and relative risks of dilatation and evacuation versus saline instillation for abortion at 13-20 menstrual weeks' gestation

Complications and Treatment	Rate per 100 Abortions		Relative Risk[a]	95% Confidence Interval
	D&E	Saline		
Major complications	0.69	1.78	2.6	1.9-3.6
Fever ≥ 38°C for ≥1 day	1.34	5.11	3.8	3.1-4.7
Endometritis	0.85	2.45	2.9	2.2-3.8
Hemorrhage	0.71	1.77	2.5	1.8-3.4
Retained products of conception	0.90	29.38	32.6	28.0-37.9
Urinary tract infection	0.18	0.79	4.4	2.5-7.9
Cervical injury	1.16	0.58	0.5	0.4-0.7
Uterine perforation	0.32	0.05	0.1	0.1-0.4
Operative treatment of complications				
Curettage or manual evacuation of the uterus	0.98	34.10	34.7	30.2-40.0
Cervical suture	1.00	0.43	0.4	0.3-0.6

[a] *Rate of saline instillation divided by rate of dilatation and evacuation (with 95% confidence interval).*

Document #13

AMERICAN PUBLIC HEALTH ASSOCIATION

Resolution
Adopted
November, 1979

THE RIGHT TO SECOND TRIMESTER ABORTION

The American Public Health Association,

Recognizing that it has consistently advocated women's right to abortion (Resolution #7626), physicians' freedom to perform abortion, and state legislation for legal abortion (#6718); and has urged the removal of state statutes restricting abortion (#7118), and supported the inclusion of abortion in public funding (#7025);

Acknowledging that although the United States Supreme Court has recognized women's right to abortion to the point of viability in the 1973 Doe vs. Wade decision, anti-abortion groups are harrassing women seeking abortions, as well as abortion providers across the country, and are creating immense pressure on physicians who perform later abortion procedures; and

Further while acknowledging the greater safety of first trimester abortions, it is recognized that women who seek later termination abortions are often treated disrespectfully by hospital personnel who oppose abortion; and

Noting that only 9 percent of legal abortions are performed in the second trimester of pregnancy; that greater use of the dilatation a evacuation procedure make it possible to perform the vast majority of second trimester abortions during or prior to the 16th week after the last menstrual period (LMP), which is the 14th week of pregnancy; and that most women who seek abortions after the 16th wee LMP are facing severe social and health circumstances, such as pregnancy at a very young age or involving a fetus with known seriou congenital abnormalities or disease; and

Noting that through curtailment of funding at both the federal and state levels, poor women have seen their right to abortion erode; therefore

1. Renews its support of women's right to abortion up to and to the point of viability.

2. Urges strong opposition to local and state proposed or enacted ordinances which present misleading and nonfactual information which may be perceived to frighten and harass women who choose abortion and health care providers performing these abortions.

3. Urges endorsement of educational programs which train physicians and health care personnel to provide safe later abortion technique of Dilatation and Evacuation and saline infusion.

4. Urges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certifications.

Reference:

1. Grimes DA, et al: Mid-trimester abortion by dilatation and evacuation: a safe and practical alternative. N. Engl. J. Med. 296: 1141-1145, 1977.

Document #14

UNPUBLISHED

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

No. 80-1431

Chris Simopoulos, M.D., Appellant,

-v-

Virginia State Board of Medicine; Marshall Coleman, Attorney General of Virginia; Fairfax Hospital Ass'n; and Potomac Hospital; their agents, successors, and those in concert with them, Appellees.

Appeal from the United States District Court for the Eastern District of Virginia, at Alexandria. Oren R. Lewis, Senior District Judge

---

Submitted July 24, 1980 Decided August 18, 1980.

Before BUTZNER and RUSSELL, Circuit Judges.

(Roy Lucas, Lucas & Miller, P.C., on brief) for appellant; (Marshall Coleman, Attorney General; James E. Ryan, Jr., Deputy Attorney General; Gregory M. Luce, Assistant Attorney General on brief) for appellees.

PER CURIAM:

Chris Simopoulos, M.D., moves for restoration of his license to practice medicine in Virginia pending an appeal from a district court order denying his request for an injunction against the Virginia State Board of Medicine. We grant the motion.

Simopoulos operates a clinic in Northern Virginia, where at the request of a minor patient in her second trimester of pregnancy, he injected a saline solution to abort a fetus. He was convicted of violating Va. Code §§ 18.2-71, 2-73, which prohibit second trimester abortions outside of licensed hospitals. Simopoulos challenges the constitutionality of these sections on two grounds: hospitalization is not necessary for the health of a woman undergoing a second trimester abortion; and the only hospitals allowing second trimester abortions in the Northern Virginia area require parental consent for minor patients.

After Simopoulos's conviction, his license to practice medicine in Virginia was summarily revoked in accordance with Va. Code § 54.321.2. Simopoulos then brought suit in district court under 42 U.S.C. § 1983 charging that his license had been unconstitutionally revoked. The district court denied his request for an injunction and dismissed his complaint.

Simopoulos appealed the dismissal of his complaint to this court and requested an injunction pending appeal. The pleadings disclosed that within a few weeks the Board of Medicine would consider his application for reinstatement. Perceiving no irreparable harm, we summarily denied his petition.

Simopoulos now has been heard by the Board. He introduced evidence from recognized authorities to prove the safety of his procedures, and he presented supporting letters from other members of the Northern Virginia medical community attesting to his character and ability. The state presented no evidence other than proof of his conviction.

Virginia Code § 54.321.2 allows reinstatement on the vote of three-fourths of the Board members based on consideration of three criteria:

> (i) the likelihood of irreparable damage to the practitioner if his . . . license should be . . . revoked during the pendency of an ultimately successful appeal,
>
> (ii) the likelihood of injury or damage to patients or the public if the license . . . is not suspended or revoked, and
>
> (iii) the seriousness of the offense.

The Board voted 9 to 4 in favor of Simopoulos, but this poll did not satisfy the requirement that three-fourths of the members must vote for reinstatement.

Following the hearing, Simopoulos renewed his request for an injunction pending appeal. Airport Commission of Forsyth

County, North Carolina v. Civil Aeronautics Board, 296 F.2d 95 (4th Cir. 1961), governs our consideration of Simopoulos's motion. He must show that: (1) he will be irreparably injured without the injunction; (2) the other parties in interest will not be substantially harmed; (3) the injunction is in accord with the public interest; and (4) there is a strong likelihood of success on the merits of the appeal.

Under the Board's decision, Simopoulos will not be allowed to practice medicine during the pendency of his criminal appeal, which the Assistant Attorney General estimates may take several years. The denial of his right to practice his profession for an extended period establishes irreparable harm.

The interest of the state and the public are closely related. If we do not grant an injunction, Simopoulos's patients will be deprived of his services for several years. If we grant the injunction, we perceive no injury to the public. The record includes a resolution of the American Public Health Association in favor of allowing second trimester abortions in licensed clinics; a resolution of the Executive Committee of the Potomac Hospital Medical Staff supporting Simopoulos's reinstatement; and letters from the pathologist of Potomac Hospital and two professors of George Washington University, one of whom was also chairman of obstetrics for Fairfax Hospital

and now teaches obstetrics at George Washington. All of the letters attest to Simopoulos's skill and reputation. The only expert to testify at the criminal trial approved of Simopoulos's clinical facilities and his methods. The lack of harm to the public interest is also indicated by the vote of a majority of the doctors on the Board of Medicine to reinstate his license.

The merits of Simopoulos's appeal in this court depend in part on the merits of his criminal appeal. At this stage of the proceedings, we observe, without reaching any definitive conclusion, that, although the Supreme Court has not addressed the precise issue, Simopoulos's position commands respectable support. Planned Parenthood v. Ashcroft, 483 F. Supp. 679 (W.D. Mo. 1980); Margaret S. v. Edwards, 488 F. Supp. 181 (E.D. La. 1980). Cf. Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Hallmark Clinic v. North Carolina Department of Human Resources, 380 F. Supp. 1153, 1158-59 (E.D.N.C. 1974) (three-judge court).

Accordingly, we grant Simopoulos's motion, and we will enter an order requiring the restoration of his license pending appeal, conditioned on his compliance with the Virginia abortion laws.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., Naim S. Kassar, M.D., Reproductive Health Services, Allen S. Palmer, D.O., Appellees,

v.

John ASHCROFT, Attorney General of State of Missouri, Ralph L. Martin, Prosecuting Attorney of Jackson County, Missouri, Appellants.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., Naim S. Kassar, M.D., Reproductive Health Services, Allen S. Palmer, D.O., Appellants,

v.

John ASHCROFT, Attorney General of State of Missouri, Ralph L. Martin, Prosecuting Attorney of Jackson County, Missouri, Appellees.

Nos. 80-1130, 80-1530.

United States Court of Appeals, Eighth Circuit.

Submitted Nov. 17, 1980.

Decided Nov. 30, 1981.

Action was brought challenging constitutional validity of Missouri statutes regulating abortions. The United States District Court for the Western District of Missouri, Elmo B. Hunter, J., 483 F.Supp. 679, denied injunctive relief but issued declaratory judgment holding all or part of sections of the statutes unconstitutional, and appeal and cross appeal were taken. After remand, 655 F.2d 848, the Court of Appeals, Lay, Chief Judge, held that: (1) statute which required that second trimester abortions be performed in the hospital was unconstitutional, but (2) statute, which required physicians to complete individual complication reports concerning postabortion care provided by them, was to be interpreted as requiring physicians to report only information which was reasonably available to them, and, as so interpreted, the statute was constitutional.

Affirmed.

1. Abortion and Birth Control ⇐1.30

State legislation which creates substantial interference with and imposes a direct burden on a woman's decision to have an abortion is to be evaluated to determine if it reasonably relates to state's interest in maternal health.

2. Abortion and Birth Control ⇐1.30

Missouri statute which requires that second trimester abortions be performed in a hospital was unconstitutional, in light of fact that dilation and evacuation was the most used and safest procedure for second trimester abortions, that hospitalized D & E's were more expensive than nonhospitalized D & E's and that nonhospitalized D & E's could not reasonably be considered more dangerous than hospitalized D & E's. V.A.M.S. §§ 188.025, 188.052, subd. 2.

3. Abortion and Birth Control ⇐1.30

Missouri statutory requirement that physicians complete individual complication reports concerning postabortion care provided by them was not subject to strict scrutiny analysis in determining constitutionality of such requirement, in light of fact there were no suspect classifications or fundamental rights at stake. V.A.M.S. § 188.052, subd. 2.

4. Abortion and Birth Control ⇐1.30

Missouri statute which required physicians to complete individual complication

reports concerning postabortion care provided by them was to be interpreted as requiring physicians to report only information which was reasonably available to them, and the statute, as so interpreted, was reasonably related to state's interest in protecting maternal health, and, thus, was constitutional. V.A.M.S. § 188.052, subd. 2.

Before LAY, Chief Judge, HENLEY, Circuit Judge, and HARRIS,* Senior District Judge.

LAY, Chief Judge.

This supplemental opinion is necessitated by reason of our previous certification to the district court relating to two issues. In our original opinion, we vacated the district court's finding that the hospitalization requirement for second trimester abortions, under section 188.025 of the Missouri statutes, is unconstitutional. We remanded that issue to the district court for further proceedings and findings as to whether the hospitalization requirement is a substantial burden on a woman's decision to have an abortion and, if so, whether the state has shown a compelling state interest which justifies the requirement. We also vacated the district court's finding that the state may require a physician to file postabortion complication reports under section 188.052.2 and remanded this provision for reconsideration in view of the argument made by the parties.

In accord with our certification the district court took additional evidence[1] and made further findings regarding the statute's hospitalization requirements for all second trimester abortions.[2]

The district court, the Honorable Elmo B. Hunter presiding, found: (1) only one hospital in Missouri currently performs second trimester dilation and evacuation (D&E) procedures; (2) second trimester D&E procedures performed in a hospital are generally significantly more expensive than the same procedures performed in an outpatient facility; and (3) requiring all second trimester abortions to be performed in a hospital results in fewer second trimester procedures being performed than if hospitalization was not required. As a result, the district court found the second trimester D&E procedure, the safest post-12 week abortion technique currently available, is an alternative which is not available to many pregnant women in Missouri. On this basis Judge Hunter found that section 188.025 creates a substantial interference with and imposes a direct burden on a woman's decision to have an abortion.

I. *Second Trimester Hospitalization Requirement.*

[1] Section 188.025 requires that second and third trimester abortions be performed in a hospital. Mo.Ann.Stat. § 188.025 (Vernon). If state legislation creates substantial interference with and imposes a direct burden on a woman's decision to have an abortion, then the state requirement is to be evaluated to determine if it reasonably relates to the state's interest in maternal health. *Roe v. Wade*, 410 U.S. 113, 164, 93 S.Ct. 705, 732, 35 L.Ed.2d 147 (1973); *Planned Parenthood Ass'n v. Ashcroft*, 655 F.2d 848, 854 (8th Cir. 1981).

* Oren Harris, Senior District Judge, Eastern and Western Districts of Arkansas, sitting by designation.

1. Further evidence was taken on these issues in a hearing conducted on August 6-7, 1981. At that hearing, plaintiffs elicited testimony from Judith A. Widdicombe, President and Executive Director of Reproductive Health Services; Wayne Schramm, Director of the Bureau of Health Data Analysis of the Missouri Division of Health; Dr. Stanley Henshaw, Senior Research Associate at the Alan Guttmacher Institute; and Dr. Samuel G. Eubanks, Jr., a board certified specialist in the fields of obstetrics and gynecology. Defendants presented no testimony at this hearing, but at its conclusion did introduce into evidence the deposition of Dr. Willard Cates, taken on July 21, 1981, in Atlanta, Georgia. The deposition of Dr. Cates was duly received by the court.

2. Section 188.025 states:

> Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital.

Mo.Ann.Stat. § 188.025 (Vernon).

[2] This court concluded previously, and additional evidence presented to the district court reinforces the conclusion, that D&E is the most used and safest procedure for second trimester abortion. *Ashcroft*, 655 F.2d at 855.

At the original trial of this action, the district court concluded that second trimester D&E was available only in one hospital in Missouri. That conclusion rested solely on the personal knowledge of two physicians, neither of whom testified that he was familiar with the policies of the hospitals throughout the state. However, evidence presented at the evidentiary hearing persuasively corroborates the district court finding.[3] The state did not dispute that any hospital other than Truman Medical Hospital has performed or is willing to perform second trimester abortions using the D&E procedures.[4]

The record demonstrates that hospitalized D&E's are more expensive than nonhospitalized D&E's. There exists evidence that some hospitalized second trimester D&E procedures are twice as expensive as nonhospitalized D&E procedures.[5] The district court concluded from the evidence that requiring hospitalized second trimester abortions places a financial burden on many women seeking such abortions.[6] On the basis of the record presented, this finding is not clearly erroneous.

Since section 188.025 creates a substantial interference with and imposes a direct burden on a woman's decision to have an abortion, the state has the burden of showing that Missouri's requirement reasonably relates to the protection of the woman's health. As we stated in our previous decision, the state must show that nonhospitalized D&E procedures can reasonably be con-

3. Wayne Schramm, the Director of the Bureau of Health Data Analysis for the Missouri Center for Health Statistics, testified that in 1981 his office began to record second trimester abortions by the D&E method. Only one hospital reported performing any second trimester abortions by the D&E procedure. This is the same hospital, Truman of Kansas City, reported in the previous proceedings before the court.

Stanley Henshaw, Senior Research Associate at the Alan Guttmacher Institute, which collects and analyzes abortion statistics on a state-by-state basis, testified that in 1979 and 1980, three hospitals reported one or more second trimester abortions by any method. The Kansas City hospital did more than 99 per cent of all second trimester abortions in those two years. One hospital reported one second trimester abortion in each of those two years; the other reported three abortions in each of the two years. He testified that the Institute inferred that those latter two hospitals are not really making abortion services available to women given the infrequency of second trimester abortions at those two hospitals.

4. Dr. Samuel G. Eubanks, Jr., a practicing physician in Louisville, Kentucky, specializes in obstetrics and gynecology. He practices in an office that has performed 15,500 abortions since 1976; he personally has performed approximately 1,400 second trimester D&E's. He testified that in Kentucky the average cost of a nonhospitalized second trimester abortion was about one-half the cost of what it would be in the hospital.

In the original proceedings, witnesses testified that the increase in the cost burden to the woman of obtaining second trimester D&E's in hospitals, rather than clinics, runs from $150.00 to $1,650.00.

5. During the period when all second trimester abortions were required to be performed in hospitals, 540 procedures were performed. In 1980, when that requirement was removed, the total number of second trimester procedures performed in Missouri was 1,390, 700 of which were performed in hospitals and 690 of which were performed in outpatient facilities. Dr. Henshaw testified that Missouri met only 13 per cent of the perceived need for second trimester abortions in the state in 1979; however, it met 34 per cent of the perceived need in 1980. In 1980, there were two second trimester abortion providers in the state, Truman Medical Hospital of Kansas City and Reproductive Health Services of St. Louis, a clinic. In 1979, only Truman Medical Hospital provided second trimester abortions. Dr. Henshaw would not infer that Reproductive Health Services substantially met all the need for second trimester abortions in the St. Louis area. Dr. Henshaw also testified that nationally 9 per cent of all abortions performed were second trimester abortions. In 1979, 3.4 per cent of all abortions performed in Missouri were second trimester abortions, but in 1980, when abortions could be performed in outpatient clinics, the figure was 6.9 per cent.

Dr. Eubanks also testified that the higher cost of hospitalized second trimester D&E procedures placed a financial burden on many patients seeking abortions.

sidered more dangerous than hospital procedures, including hospitalized D&E. *Ashcroft*, 655 F.2d at 856.

The central issue is the relative safety of nonhospitalized D&E and hospitalized methods. No quantitative studies are cited which directly compare the relative safety of the two procedures. However, the district court has found explicitly that a nonhospitalized second trimester D&E procedure is just as safe as those second trimester D&E procedures conducted in hospitals.[6] Since the district court's finding is not clearly erroneous, we find that nonhospitalized second trimester D&E procedures are no more dangerous to maternal health than hospitalized procedures. Consequently, we hold that section 188.025 is not reasonably related to maternal health and, therefore, the requirement that *all* second trimester abortions be performed in hospitals is unconstitutional. *See Planned Parenthood v. Danforth*, 428 U.S. 52, 76, 96 S.Ct. 2831, 2844, 49 L.Ed.2d 788 (1976).

II. *Recordkeeping.*

Subsection 188.052.2 of the Missouri statutes requires physicians to complete individual complication reports concerning post-abortion care that they provide.[7] Plaintiffs argue that a physician may be faced in completing these reports with the situation where the patient will not or cannot provide the necessary information. Plaintiffs argue that the physician is then faced with the dilemma of filing a report with incomplete data, thereby subjecting himself to criminal liability, or refusing to treat the patient.

The district court was not convinced that a reasonable interpretation of subsection 188.052.2 would place physicians in the di-

6. We are aware of the Sixth Circuit's decision in *Akron Center for Reproductive Health, Inc. v. City of Akron*, 651 F.2d 1198 (6th Cir. 1981). In *Akron*, the plaintiffs tried to show that because of the D&E procedure, abortion through the 17th or 18th week of pregnancy is safer than childbirth. Thus, they argued that, under *Roe v. Wade*, the state's interest in maternal health does not become compelling before that time and the requirement that all second trimester abortions be performed in hospitals is unconstitutionally overbroad.

In the district court, the plaintiffs presented evidence that early second trimester clinical abortions were just as safe as second trimester abortions performed in hospitals. The district court, however, did not find plaintiff's evidence so convincing that it was willing to discard the Supreme Court's formulation in *Roe v. Wade*.

The Sixth Circuit noted that two district courts held that the state's interest in the health of the pregnant woman does not become compelling until the 18th week of pregnancy. *Margaret S. v. Edwards*, 488 F.Supp. 181, 194–96 (E.D.La.1980) and *Planned Parenthood Ass'n v. Ashcroft*, 483 F.Supp. 679, 687 (W.D. Mo.1980). The Sixth Circuit found the rationale of these decisions persuasive. However, it also found that, by affirming *Gary-Northwest Indiana Women's Services, Inc. v. Bowen*, 496 F.Supp. 894, 896–902 (N.D.Ind.1980), *aff'd sub nom. Gary-Northwest Indiana Women's Services, Inc. v. Orr*, 451 U.S. 934, 101 S.Ct. 2012, 68 L.Ed.2d 321 (1981), the Supreme Court had an opportunity to retreat from the "bright line" drawn in *Roe v. Wade* and declined to do so. Thus, it affirmed the district court's holding that the statute was constitutional.

Evidence adduced at the original trial in this cause and the evidentiary hearing suggests that the nonhospitalized procedures may actually be safer. The evidence cited in the original opinion is noted by this court in *Ashcroft*, 655 F.2d at 857 n.12. At the evidentiary hearing, Dr. Willard Cates, Chief of the Abortion Surveillance Branch of the Family Planning Evaluation Division at the Center for Disease Control, stated that in his opinion D&E procedures through 16 weeks after the last menstrual period (14 weeks after conception) are just as safe in outpatient facilities as they are in hospitals. The district court views the testimony of Dr. Cates to say that section 188.025 prevents D&E procedures, particularly in the 15th and 16th weeks after the last menstrual period. Also, the district court concluded that, even though testimony tended to show that hospitals are better equipped to treat postabortion infections, such infections do not occur until 24 to 72 hours after the procedure is completed. By that time a patient will have been dismissed from either a hospital or an outpatient facility.

7. Subsection 188.052.2 states:

> An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such post-abortion care. This report shall include:
>
> (1) The date of the abortion;
>
> (2) The name and address of the abortion facility or hospital where the abortion was performed;
>
> (3) The nature of the abortion complication diagnosed or treated.

Mo.Ann.Stat. § 188.052.2 (Vernon).

lemma envisioned by plaintiffs. The court interprets the statute to require physicians to complete the reports using data that is reasonably available to them. That interpretation is shared by the Missouri attorney general. Since physicians are required only to report information that is reasonably available to them, section 188.052.2 does not place physicians in the dilemma of refusing treatment to patients or subjecting themselves to criminal liability by filing an incomplete report when the patient refuses to or cannot provide data to be included in the post-abortion complication report.

[3, 4] The reporting requirement is not subject to strict scrutiny analysis, as there are no suspect classifications or fundamental rights at stake. The reporting requirement need only be rationally related to a constitutionally permissible purpose. The district court, finding that the reporting requirements are consistent with the holding of *Planned Parenthood v. Danforth*, *supra*, ruled that it is rationally related. The requirements of subsection 188.052.2 provide the state with information that is helpful to medical assistance, judgments, and medical standards. Thus, it is also reasonably related to the state's interest in protecting maternal health. *Connecticut v. Menillo*, 423 U.S. 9, 10–11, 96 S.Ct. 170, 171, 46 L.Ed.2d 152 (1975); *Roe v. Wade*, 410 U.S. at 164, 93 S.Ct. at 732.[8]

III. *Conclusion.*

We affirm the district court's finding that the requirement of hospitalization for second trimester abortions under section 188.025 is unconstitutional. We affirm the district court's finding that a state may require a physician to file postabortion complication reports under subsection 188.052.2. These rulings shall be incorporated into our prior judgment, *Planned Parenthood Ass'n v. Ashcroft*, 655 F.2d 848 (8th Cir. 1981), and the integrated judgment as now amended shall issue.

It is so ordered.

8. Dr. Cates testified that keeping the type of statistics mandated by the statute has been shown to contribute to the safety of abortion procedures.

Document #16

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al., Plaintiffs-Appellants, Cross-Appellees,

v.

CITY OF AKRON, et al., Defendants-Appellees, Cross-Appellants,

Francois Seguin, et al., Intervenors Defendants-Appellants.

Nos. 79-3700, 79-3701 and 79-3757.

United States Court of Appeals, Sixth Circuit.

Argued Oct. 23, 1980.

Decided June 12, 1981.

Rehearing Denied July 10, 1981.

Petition for Rehearing of Intervenors Denied July 22, 1981.

Three corporations operating abortion clinics and Cincinnati physician who had performed abortions in one clinic brought action challenging validity of Akron, Ohio, abortion ordinance. The District Court, 479 F.Supp. 1172, issued an injunction. Appeal was taken. The Court of Appeals, Lively, Circuit Judge, held that: (1) ordinance requiring parental consent for women under 18 was unconstitutional; (2) ordinance re-

quiring parental notice for certain women was constitutionally permissible regulation insofar as it applied to immature minors who lived with their parents, who were dependent upon them, and were not emancipated by marriage or otherwise; (3) ordinance setting forth detailed and specific information which must be given to each patient by attending physician was impermissible; (4) ordinance requiring doctor to make certain disclosures in all cases was constitutional; (5) ordinance requiring 24-hour waiting period was unconstitutional; (6) ordinance requiring that every abortion subsequent to end of first trimester be performed in hospital was constitutional; and (7) ordinance relating to disposal of fetus remains was impermissibly vague.

Affirmed in part and reversed in part.

Cornelia G. Kennedy, Circuit Judge, filed an opinion concurring in part and dissenting in part.

1. Abortion and Birth Control ⇐.50

The state's right to regulate abortions, at each stage of pregnancy, must rest on a compelling and legitimate state interest.

2. Constitutional Law ⇐82(1)

Once it is found that a regulation constitutes a direct state interference with protected activity, that regulation is subject to strict scrutiny.

3. Abortion and Birth Control ⇐.50

If an abortion regulation results in a legally significant impact or consequence on the first trimester abortion decision, it is invalid.

4. Abortion and Birth Control ⇐.50

The section of the city's abortion ordinance requiring parental consent was unconstitutional. U.S.C.A.Const. Amends. 1, 14.

5. Abortion and Birth Control ⇐.50

Section of a city's abortion ordinance requiring physician to notify the parents of a woman under the age of 15 years that the woman is seeking an abortion is a constitutionally permissible regulation insofar as it applies to immature minors who live with their parents, are dependent upon them and are not emancipated by marriage or otherwise. U.S.C.A.Const. Amends. 1, 14.

6. Abortion and Birth Control ⇐.50

Section of city's abortion ordinance setting forth detailed and specific information which must be given to each abortion patient by attending physician is impermissible as unduly encumbering the exercise of the patient's constitutionally protected rights. U.S.C.A.Const. Amends. 1, 14.

7. Abortion and Birth Control ⇐.50

Section of a city's abortion ordinance requiring a physician to make certain disclosures in all cases regardless of his own professional judgment as to the desirability of doing so was invalid in that it sought to impose requirement which was unsupported by compelling state interest but had the effect of encumbering the exercise of the pregnant woman's constitutional rights. U.S.C.A.Const. Amends. 1, 14.

8. Abortion and Birth Control ⇐.50

Section of city abortion ordinance requiring a 24-hour waiting period between the time a pregnant woman signs consent form and time an abortion may be performed is unconstitutional in that it caused a legally significant impact or consequence on abortion decision and there was insufficient evidence that a compelling state interest was served by the requirement. U.S.C.A.Const. Amends. 1, 14.

9. Abortion and Birth Control ⇐.50

Section of a city's abortion ordinance requiring that every abortion subsequent to end of the first trimester of pregnancy be performed in a hospital is constitutional particularly in light of the state's compelling interest after the first trimester. U.S.C.A.Const. Amends. 1, 14.

10. Federal Civil Procedure ⇐101

It was not an abuse of discretion to deny the request of a pregnant woman and the physician who performed a post first-trimester abortion to proceed by pseudonyms to challenge section of city's abortion ordinance forbidding abortions after viabili-

ty except to prevent death or impairment of health of pregnant woman.

11. Municipal Corporations ⇐121

A physician plaintiff did not have jus tertii standing to represent pregnant women who desired abortions after viability but who were not before the court in action challenging city ordinance forbidding abortions after viability except to prevent death or impairment of health of pregnant women.

12. Municipal Corporations ⇐121

Physician, who did not reside in Akron, but who had performed first-trimester abortions at one of the clinics in Akron had standing to challenge Akron abortion ordinance forbidding abortions after viability except to prevent death or impairment of health of pregnant woman.

13. Abortion and Birth Control ⇐.50

City abortion ordinance requiring that the remains of an aborted fetus be disposed of in a humane and sanitary manner was invalid as being impermissibly vague as to definition of a criminal act.

Stephan A. Landsman, Cleveland-Marshall College of Law, Cleveland State University, Cleveland, Ohio, Gordon J. Beggs, ACLU of Cleveland Foundation, Cleveland, Ohio, for plaintiffs-appellants, cross-appellees.

Dennis Haines, Youngstown, Ohio, Patricia A. Vance, Akron, Ohio, Janet Benshoof, American Civil Liberties Union, Reproductive Freedom Project, New York City, Robert P. App, Bruce A. Campbell, American Civil Liberties Union of Ohio Foundation, Inc., Columbus, Ohio, for plaintiffs-appellants, cross-appellees.

Alan G. Segedy, Segedy & Umbaugh, David G. Umbaugh, Akron, Ohio, for Sequin and Black.

James Bickett, Cuyahoga Falls, Ohio, Robert A. Destro, Milwaukee, Wis., for City of Akron, et al.

Dara Klassel, Planned Parenthood-World Population, Harriet F. Pilpel, New York City, Nadine Taub for American Pub. Health Association, Rutgers University School of Law, Women's Rights Litigation Clinic, Newark, N. J., for amicus curiae Planned Parenthood Federation of America, et al.

Before LIVELY and KENNEDY, Circuit Judges, and GIBSON,* District Judge.

LIVELY, Circuit Judge.

These consolidated appeals seek review of various holdings of the district court in an action challenging the constitutionality of an ordinance of the City of Akron, Ohio which regulates abortions. By its terms the ordinance was to become effective May 1, 1978, and the present suit was filed in the district court on April 19, 1978. The plaintiffs are three Ohio corporations that operate out-patient abortion clinics in Akron and a physician who has performed abortions at one of the clinics. The defendants are the City of Akron, its mayor and director of public health and the police prosecutor of Akron. The district court permitted participation as defendants by a group of intervenors "solely in their independent capacity as parents of unmarried minor daughters of child-bearing age."

I. The District Court Opinion

The opinion of the district court is reported at 479 F.Supp. 1172 (1979), and the ordinance is reprinted as an appendix to the opinion. The district court concluded that the ordinance is severable and examined it on a section-by-section basis. We agree that the ordinance is severable and will follow a similar procedure in our analysis.

A.

The three clinics provide abortions only during the first trimester of pregnancy but are willing to perform early second trimester abortions if permitted to do so. The

*The Honorable Benjamin F. Gibson, Judge, United States District Court for the Western District of Michigan, sitting by designation.

plaintiff physician has performed first trimester abortions at one of the clinics. The district court described the operation of the clinics as follows:

> The patients for whom the clinics provide their services range in age from about twelve years to approximately forty-five years. Two of the clinics provide abortions on three days a week (Wednesday, Friday, and Saturday) and the third provides abortions two days a week (Wednesday and Saturday).
>
> Patients usually make their first contact with one of the clinics over the telephone. If a woman telephones and indicates that she desires an abortion and that her pregnancy has not progressed beyond the end of the first trimester, she will be given an appointment for one of the "procedure days." When the patient arrives at the clinic on the day of her appointment she is asked certain questions about her medical history and her pregnancy. She also participates in a group counseling session with counselors employed by the respective clinics. These counselors have varying degrees of qualifications, none, however, is a physician. During the group counseling session, the patients are given information concerning the procedure to be performed upon them, information on birth control techniques, and after-care instructions. At some time near the close of her group counseling session, each patient is asked to sign a document acknowledging her informed consent to the performance of an abortion.
>
> A patient's first contact with the physician who is to perform the abortion procedure usually occurs when she is taken into the operating room. At that time, the physician reviews the patient's medical chart and asks the patient if she has any questions. The doctor then performs a pelvic examination. If the pelvic examination does not reveal any medical problems and, further, indicates that the pregnancy has not progressed beyond the first trimester, the abortion usually will then be performed. There was some evidence that if the physician sensed that the patient was ambivalent concerning her decision, he would suggest that she return at another time after she had had some additional time to consider alternatives to abortion.
>
> The abortion method used at the clinics is dilation and suction curettage (D&C). The procedure itself takes approximately five minutes.

479 F.Supp. at 1181/82.

B.

We will limit our consideration of the constitutionality of the Akron ordinance to due process issues. The district court gave full and thoughtful consideration to claims of the plaintiffs that the ordinance violates the First Amendment requirement of separation of church and state and the Equal Protection Clause of the Fourteenth Amendment and rejected these claims. We agree with the treatment of these contentions by the district court and with its conclusion, and will not repeat them here.[1]

The district court held that no plaintiff had standing to contest the validity of several provisions of the ordinance. Except where the parties have specifically appealed these rulings, standing will not be discussed in this opinion. The appealed holdings of the district court, described in general terms, were as follows:

(1) Section 1870.03, requiring all abortions after the first trimester to be performed in hospitals, was held valid.

(2) Section 1870.04, dealing with abortions after viability, was not considered by the court because no plaintiff was found to have standing.

(3) Section 1870.05, requiring notice to one of the parents or the legal guardian of a minor seeking an abortion and consent to such an abortion, was held invalid.

1. The district court's First Amendment holding is strongly reinforced by the recent opinion of the Supreme Court in *Harris v. McRae*, 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980).

(4) Section 1870.06(A), requiring informed written consent of the woman seeking an abortion, was held valid.[2]

(5) Section 1870.06(B), detailing the information required to be given by the attending physician in obtaining consent of the woman seeking an abortion, was held invalid.

(6) Section 1870.06(C), requiring the attending physician to detail the particular risks associated with the patient's pregnancy and the abortion technique to be employed, was held valid.

(7) Section 1870.07, requiring a 24-hour waiting period between the time the consent is signed and the abortion is performed, was held valid.

(8) Section 1870.16, requiring that the remains of an aborted fetus be disposed of in "a humane and sanitary manner," was held invalid for vagueness.

II. The Standard for Testing the Validity of the Ordinance

The plaintiffs contend on appeal that the district court applied an erroneous standard in testing the constitutionality of the various provisions of the ordinance. Rather than requiring the City to demonstrate the necessity of the various provisions to further a compelling interest of the City, the district court tested the ordinance by less stringent standards. In short, it is the position of the plaintiffs that the district court failed to subject the ordinance to the strict scrutiny required by controlling decisions of the Supreme Court.

A.

The district court acknowledged that the pioneering opinion in the field of abortion law, *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), speaks in terms of the fundamental right of a pregnant woman to make an abortion decision in consultation with her physician and holds that regulations limiting fundamental rights may be justified only by some compelling state interest. Further, any legislative enactment which affects such rights must be narrowly drawn to express only the legitimate state interest at stake. The first point at which the Supreme Court identified a compelling state interest—an interest in the health of the pregnant woman—was "at approximately the end of the first trimester." *Id.* at 163, 93 S.Ct. at 732. However, after reviewing Supreme Court decisions subsequent to *Roe v. Wade*, the district court concluded that a state may impose certain limitations on the right to an abortion, even in the first trimester, so long as these regulations do not "unduly burden" the decision-making process and are rationally related to a legitimate purpose of the state. This conclusion was summarized in the following language of the district court:

> It becomes clear, therefore, from an examination of the cases decided since *Roe*, that not all regulation of first trimester abortion providers is impermissible. An absolute prohibition of first trimester abortions could only be justified by a compelling state interest. Likewise, regulations that afford the power to veto a woman's decision to terminate her pregnancy must be supported by a compelling state interest. *See [Planned Parenthood of Central Mo. v.] Danforth*, 428 U.S. [52] at 67–72, 96 S.Ct. 2831 [at 2840–2842, 49 L.Ed.2d 788]. Regulations that interfere with a woman's privacy to a lesser degree, however, require a lesser showing by the state to withstand constitutional attack: "As *Whalen* [*v. Roe*, 429 U.S. 589, 97 S.Ct. 869, 51 L.Ed.2d 64 (1977)] makes clear, the right in *Roe v. Wade* can be understood only by considering both the woman's interest and the nature of the State's interference with it." *Maher [v. Roe], supra* 432 U.S. [464] at 473, 97 S.Ct. [2376] at 2382 [53 L.Ed.2d 484].

Accordingly, the Court must determine the degree that each section of Ordinance Number 160–1978 interferes with a woman's constitutional right, in consultation

2. Though the holding with respect to section 1870.06(A) was not appealed, it is listed for clarity, since the holdings as to the related sections 1870.06(B) and 1870.06(C) were appealed and are discussed in this opinion.

with her physician, to choose to terminate her pregnancy. That interference must then be weighed against any valid state interest furthered by such section. Finally, it will be necessary to consider the combined effect of all the various sections not independently unconstitutional to determine whether their combined impact results in such a degree of interference with the constitutional right at issue to result in a finding of invalidity.[22]

[22] Every regulation imposed upon first trimester abortions is going to have some impact upon a woman's right to decide to terminate her pregnancy. That is, any regulation that makes "the physician's work more laborious or less independent," *Whalen v. Roe*, 429 U.S. 589, 605 n. 33, 97 S.Ct. 869, 879 n. 33, 51 L.Ed.2d 64 (1977), is, at least, going to make it more expensive for a woman to effectuate her abortion decision. If the combined weight of a number of regulations, not independently unconstitutional, were to serve to make it unduly burdensome for a woman to carry out her decision, those sections would be invalid.

479 F.Supp. at 1200.

B.

We believe the district court read too much into the post-*Wade* decisions of the Supreme Court. In *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976), the Court found, at least implicitly, that a regulation requiring a pregnant woman to sign a written consent to an abortion did not "restrict the decision of the patient and her physician regarding abortion during the first stage of pregnancy." 428 U.S. at 66, 96 S.Ct. at 2840. The Court also found, explicitly, that a record-keeping requirement of the Missouri statute imposed "no legally significant impact or consequence on the abortion decision or on the physician-patient relationship." *Id.* at 81, 96 S.Ct. at 2846. The validation of these provisions of the Missouri statute was based upon a finding that neither provision involved an intrusion into the decision-making process sufficient to require constitutional analysis. The decision was not based on a holding that the constitutionality of the statute could rest on something less than a compelling state interest. There is no indication in *Danforth* that if the intrusions had been found significant, any state interest less than a compelling one would have served to validate them. The most that may be inferred from *Danforth* is that there are some *slight* intrusions which the state may make into the decision-making process, even during the first trimester of pregnancy.[3] These intrusions are not "legally significant," and do not trigger a further constitutional analysis.

Maher v. Roe, 432 U.S. 464, 97 S.Ct. 2376, 53 L.Ed.2d 484 (1977), offers even less support than *Danforth* for the proposition that the constitutionality of the Akron ordinance may be tested by some standard less demanding than a compelling state interest. The statute under attack in *Maher* forbade the expenditure of state funds for nontherapeutic abortions while permitting such expenditures for childbirth. The plaintiffs in *Maher* argued that the statute offended the Equal Protection Clause by creating an impermissible classification. In upholding the statute the Supreme Court emphasized the differences between the funding statute before it in *Maher* and the "drastic" restrictions imposed on the abortion decision by the statute at issue in *Roe v. Wade* [410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147], 432 U.S. at 472, 97 S.Ct. at 2381–2382. Treating childbirth and abortion as two alternative medical methods of dealing with pregnancy, the state was required to demonstrate only that there was a rational relationship between the decision not to fund nontherapeutic abortions and its decision to favor childbirth over abortions. The Court repeatedly emphasized in *Maher* that the Connecticut statute dealt only with funding and did not place any limitations on the right to have an abortion. *See also, Beal v. Doe*, 432 U.S. 438, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977), and *Harris v. McRae, supra.*

[1] As the Court pointed out in *Maher*, "[t]here is a basic difference between direct

3. The record-keeping requirement was characterized by the Court as one which "approach[ed] impermissible limits" of a state's ability to regulate during the first trimester. 428 U.S. at 80, 96 S.Ct. at 2846.

state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy." 432 U.S. at 475, 97 S.Ct. at 2383 (footnote omitted). In *Roe v. Wade*, as in the present case, the state attempted "to impose its will by force of law" by making it a crime to provide services which a pregnant woman is entitled to receive. *Id.* at 476, 97 S.Ct. at 2384. Such a statute impinges directly on a protected activity and requires strict scrutiny. The district court appears to have examined only the "degree" of state interference which each provision of the Akron statute imposed upon the abortion decision. It is clear that the *nature* of the interference must also be examined. *Maher* does not provide support for the claim that an ordinance such as the one now before us may be tested by a more lenient standard. We accept the statements of the Supreme Court that its later cases do not represent a retreat from the *Roe v. Wade* holding that the state's right to regulate abortions, at each stage of pregnancy, must rest on a compelling and legitimate state interest. *E. g., Maher v. Roe, supra*, 432 U.S. at 475, 97 S.Ct. at 2383. . .

C.

Consideration of these decisions leads to the conclusion that a two-step analysis is required. First, the nature of the particular regulatory provision must be considered. If it causes no "legally significant impact or consequence" on the right of a pregnant woman, in consultation with a physician, to choose to terminate her pregnancy, it does not raise a constitutional issue. The particular provisions of the Missouri statute (written consent and record keeping) which produced the *Danforth* language relied upon by the defendants here, and the entire thrust of the statute in *Maher*, were of this kind. Only if the provision does result in such significant impact or consequence must a second inquiry be made to determine whether or not the regulatory provision serves a legitimate and compelling state interest. If a compelling state interest is found, the regulation must be examined further to determine whether it imposes an "undue burden" on the abortion decision, that is, whether it is sufficiently narrowly drawn.

[2, 3] We believe the district court applied the test of whether a provision "unduly burdens" the abortion decision at the wrong stage of its inquiry. Once it is found that a regulation constitutes "direct state interference with a protected activity," *Maher, supra*, 432 U.S. at 475, 97 S.Ct. at 2383, here the right of a pregnant woman to have an abortion, that regulation is subject to strict scrutiny. Only then, in the process of balancing the interest of the state against the method chosen to deal with it, does the "unduly burdensome" factor become important. Since the state has no compelling interest during the first trimester of pregnancy, no balancing is required. If a regulation results in a legally significant impact or consequence on a first trimester abortion decision, it is invalid. *See Roe v. Wade, supra*, 410 U.S. at 163, 93 S.Ct. at 732. Further, even though a regulation may relate to a stage of pregnancy during which the state has a compelling interest, nevertheless, the method chosen to effectuate that interest may fail if it unduly burdens the decision to obtain an abortion. As the Court said in *Charles v. Carey*, 627 F.2d 772, 777 (7th Cir. 1980), "the term 'undue burden' defines the ultimate constitutional issue, not merely the threshold requirement for strict scrutiny."

III. Provisions Affecting All Abortions

We look first at those provisions of the ordinance which apply to all abortions, which necessarily include those performed during the first trimester. Our initial inquiry is to determine if any of them directly interfere with the right of a pregnant woman and her physician to decide whether she should obtain an abortion. As the Supreme Court recently reemphasized in *Colautti v. Franklin*, 439 U.S. 379, 387, 99 S.Ct. 675, 681, 58 L.Ed.2d 596 (1979), this is in all respects a medical decision "up to the point where important state interests provide compelling justifications for intervention . . . ."

A. Parental Notice and Consent[4]

[4] The district court held sections 1870.05(A) (parental notice) and 1870.05(B) (parental consent) invalid. Though the original defendants did not appeal these holdings, the intervenors have done so. The intervenors argue that the fundamental right of parents "to control, educate, nurture and guide the actions of their minor children" is one which the state is constitutionally empowered to protect. This right has been recognized recently by the Supreme Court in connection with abortion regulations in *Danforth, supra*, 428 U.S. at 73, 96 S.Ct. at 2843; *Bellotti v. Baird*, 443 U.S. 622, 637–39, 99 S.Ct. 3035, 3045–46, 61 L.Ed.2d 797 (1979); and *H. L. v. Matheson*, — U.S. —, —, 101 S.Ct. 1164, 1171, 67 L.Ed.2d 388 (1981). While parental rights were recognized, the Court held that a "blanket" provision requiring consent of a parent or person standing *in loco parentis* may not be imposed as a condition for abortion of an unmarried minor during her first twelve weeks of pregnancy. *Danforth*, 428 U.S. at 74, 96 S.Ct. at 2843. In *Bellotti*, 443 U.S. at 643, 99 S.Ct. at 3048, the Court noted "the unique nature and consequences of the abortion decision" which make it inappropriate, on the basis of deference to parental rights, to provide a possible third-party veto over the decision of the pregnant woman and her doctor to terminate the patient's pregnancy. We believe the district court correctly applied these principles in finding section 1870.05(B) unconstitutional. *See Wynn v. Carey*, 582 F.2d 1375, 1390 (7th Cir. 1978); *Margaret S. v. Edwards*, 488 F.Supp. 181, 202–03 (E.D.La.1980); *Planned Parenthood Association of Kansas City v. Ashcroft*, 483 F.Supp. 679, 687 (W.D. Mo.1980).

[5] The decision in *H. L. v. Matheson, supra*, requires a different treatment of section 1870.05(A). The Utah statute there involved required a physician to "[n]otify, if possible, the parents or guardians of the woman upon whom the abortion is to be performed, if she is a minor or the husband of the woman, if she is married." — U.S. at —, 101 S.Ct. at 1166–67. Because the plaintiff in *H. L.* was an unmarried fifteen-year old who resided at home and was dependent on her parents the only decision of the Court was that the Utah statute was not facially unconstitutional when questioned by one in her circumstances. Justices Stewart and Powell were two of the six Court members who made up the majority. In a separate concurrence these Justices emphasized that the opinion of the Court did not decide "whether [the Utah statute] unconstitutionally burdens the right of a mature minor or a minor whose best interests would not be served by parental notification." — U.S. at —, 101 S.Ct. at 1173–74 (Powell, J., concurring).

The plaintiffs in the present case are abortion clinics and a physician. No minor female is questioning the validity of the Akron ordinance. The intervenors who appealed the portion of the district court judgment finding section 1870.05(A) invalid

4. Akron Ordinance No. 160–1978, Ch. 1870
1870.05 NOTICE AND CONSENT
(A) No physician shall perform or induce an abortion upon an unmarried pregnant woman under the age of 18 years without first having given at least twenty-four (24) hours actual notice to one of the parents or the legal guardian of the minor pregnant woman as to the intention to perform such abortion, or if such parent or guardian cannot be reached after a reasonable effort to find him or her, without first having given at least seventy-two (72) hours constructive notice to one of the parents or the legal guardian of the minor pregnant woman by certified mail to the last known address of one of the parents or guardian, computed from the time of mailing, unless the abortion is ordered by a court having jurisdiction over such minor pregnant woman.
(B) No physician shall perform or induce an abortion upon a minor pregnant woman under the age of fifteen (15) years without first having obtained the informed written consent of the minor pregnant woman in accordance with Section 1870.06 of this Chapter and
(1) First having obtained the informed written consent of one of her parents or her legal guardian in accordance with Section 1870.06 of this Chapter, or
(2) The minor pregnant woman first having obtained an order from a court having jurisdiction over her that the abortion be performed or induced.

are parents of unmarried minor daughters. Neither the maturity nor condition with respect to emancipation of these minors is shown. The decision of the Supreme Court leads to the conclusion that section 1870.05(A) is a constitutionally permissible regulation insofar as it applies to immature minors who live with their parents, are dependent upon them and are not emancipated by marriage or otherwise. Until the requirements of section 1870.05(A) are questioned by a minor who claims to be mature or emancipated or claims that notice would not be in her best interest, we cannot hold the section facially invalid. The finding that section 1870.05(A) is unconstitutional is reversed.

B. Informed Consent [5]

[6] The plaintiffs have not appealed from the district court's ruling that the general informed consent requirement of section 1870.06(A) is valid. However, the

5. Akron Ordinance No. 160-1978, Ch. 1870

1870.06 INFORMED CONSENT

(A) An abortion otherwise permitted by law shall be performed or induced only with the informed written consent of the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, given freely and without coercion.

(B) In order to insure that the consent for an abortion is truly informed consent, an abortion shall be performed or induced upon a pregnant woman only after she, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, have been orally informed by her attending physician of the following facts, and have signed a consent form acknowledging that she, and the parent or legal guardian where applicable, have been informed as follows:

(1) That according to the best judgment of her attending physician she is pregnant.

(2) The number of weeks elapsed from the probable time of the conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period or after a history and physical examination and appropriate laboratory tests.

(3) That the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members.

(4) That her unborn child may be viable, and thus capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion.

(5) That abortion is a major surgical procedure, which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

(6) That numerous public and private agencies and services are available to provide her with birth control information, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(7) That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(C) At the same time the attending physician provides the information required by paragraph (B) of this Section, he shall, at least orally, inform the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, of the particular risks associated with her own pregnancy and the abortion technique to be employed including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery, and shall in addition provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

(D) The attending physician performing or inducing the abortion shall provide the pregnant woman, or one of her parents or legal guardian signing the consent form where applicable, with a duplicate copy of the consent form signed by her, and one of her parents or her legal guardian where applicable, in accordance with Paragraph (B) of this Section.

defendants contend on appeal that the district court erred in holding section 1870.06(B) unconstitutional in its entirety. They argue that the subsections within 1870.06(B) should be considered separately and that only those requirements which fail to pass constitutional scrutiny, when considered individually, should be voided. We believe the district court properly considered section 1870.06(B) as a unit and correctly concluded that the provision setting forth detailed and specific information which must be given to each abortion patient by the attending physician is impermissible. The requirements of section 1870.06(B) impose "restrictions or regulations governing the medical judgment of the pregnant woman's attending physician with respect to the termination of her pregnancy." *Danforth*, 428 U.S. at 80, 96 S.Ct. at 2846. Such restrictions or regulations are not permitted during the first trimester of pregnancy. The district court correctly held section 1870.06(B) invalid, not because it would burden the physician, but because its effect would be to encumber the exercise of the patient's constitutionally protected right "by placing obstacles in the path of the doctor upon whom she was entitled to rely for advice in connection with her decision." *Whalen v. Roe*, 429 U.S. 589, 604 n. 33, 97 S.Ct. 869, 879 n. 33, 51 L.Ed.2d 64 (1977).

The district court concluded that section 1870.06(C) serves a valid state interest in the health of its female citizens. This section requires counseling by the attending physician and specifies that the physician must advise the patient of the particular risks associated with her own pregnancy and with the abortion technique to be employed. The district court determined that the state could rationally conclude that this counseling should be done by the attending physician rather than another individual.

[7] Section 1870.06(C) impinges on the medical judgment of the attending physician in exactly the same way as section 1870.06(B). It requires the doctor to make certain disclosures in all cases, regardless of his own professional judgment as to the desirability of doing so. Such a requirement is clearly invalid for first trimester abortions. The district court appears not to have considered the nature of the restriction imposed by the section, but only the degree. This was error. Further, the district court required only that the state demonstrate a "valid" interest in maternal health as justification for section 1870.06(C). A compelling state interest must exist to support a legally significant intrusion into the abortion decision. Finally, even assuming the existence of a compelling state interest, the district court failed to require the defendants to demonstrate that the requirements of section 1870.06(C) are narrowly drawn to serve that interest. As has been stated, the practice of all three plaintiff clinics has been for the counseling to be conducted by persons other than the doctor who performs the abortion. In the absence of a showing that the state's compelling interest in maternal health would be served by a requirement that such counseling be done by the attending physician, this section is invalid.

Rather than attempting to show the existence of a compelling state interest in the regulation, the defendants argue that the requirements of section 1870.06(C) are reasonable and do not unduly burden the abortion decision. We believe section 1870.06(C) suffers from the same infirmities as section 1870.06(B). It seeks to impose a requirement which is unsupported by a compelling state interest but has the effect of encumbering the exercise of the pregnant woman's constitutional right.

It is possible that some of the individual requirements of sections 1870.06(B) and (C) could be successfully defended. *See, e. g., Charles v. Carey, supra; Margaret S. v. Edwards, supra; Planned Parenthood Association of Kansas City v. Ashcroft, supra.* As written, however, they have the effect of going far beyond the valid requirement of section 1870.06(A) and extending the permissible reach of the informed consent provision. We affirm the holding of the district court that 1870.06(B) is invalid and reverse the holding that 1870.06(C) is constitutional.

C. Waiting Period

Section 1870.07 requires a 24-hour waiting period between the time a pregnant woman signs the consent required in section 1870.06(A) and the time an abortion may be performed. In upholding the validity of this provision, the district court relied primarily upon this court's decision in *Wolfe v. Schroering*, 541 F.2d 523 (6th Cir. 1976). The district court acknowledged that there was no claim in *Wolfe v. Schroering* that this particular regulation significantly burdened the abortion process. *Id.* at 526. In the present case the plaintiffs argue that the waiting period requires an additional trip to the clinic, making the process more expensive, imposes impermissible physical and psychological burdens on a woman seeking a first trimester abortion, and is not narrowly drawn to achieve a lawful objective.

[8] Since section 1870.07 causes a legally significant impact or consequence on the abortion decision, it cannot be applied to first trimester abortions. Assuming some state interest in postponing abortion decisions, the evidence falls far short of establishing a compelling interest which is served by the requirement. The obvious effect of the requirement is to impose upon the process of obtaining an abortion a delay which has no medical basis. Though there was evidence that a period of delay before surgery is often beneficial, there was none that an inflexible requirement of a 24-hour waiting period for an abortion serves any interest of the state, much less a compelling interest which is required under strict scrutiny analysis. Medical witnesses for the defendants testified that a reasonable "work-up" time is customary and often necessary prior to surgery. However, none related this in-hospital practice to the very brief procedures involved in early stage abortions.

The unstated purpose of section 1870.07 is to require a "cooling off period" during which second thoughts might come into play. The district court appears to have recognized this effect:

> The state interest furthered by the waiting period requirement is the insurance that a woman's abortion decision is made after careful consideration of all the facts applicable to her particular situation. This is an important state interest considering the irreversible nature and possible lasting consequences of the abortion decision.

479 F.Supp. at 1204.

Desirable as such careful consideration may be, it is beyond the state's power to require. *Charles v. Carey, supra*, 627 F.2d at 785–86; *Margaret S. v. Edwards, supra*, 488 F.Supp. at 212–13. We reverse the holding that section 1870.07 is constitutional.

IV. The Second Trimester "Hospital Only" Requirement

[9] Section 1870.03 requires every abortion subsequent to the end of the first trimester of pregnancy to be performed in a hospital. In *Roe v. Wade*, the Supreme Court found that "in the light of present medical knowledge," the state's legitimate interest in the health of the expectant mother became compelling at approximately the end of the first trimester. 410 U.S. at 163, 93 S.Ct. at 731. In that decision the Court gave as one specific example of a constitutional regulation a requirement that abortions subsequent to the first trimester be performed in hospitals. *Id.*

The thrust of the plaintiffs' proof in the present case was to the effect that a procedure known as dilatation and evacuation (D & E), requires a reexamination of certain assumptions of the Court in *Roe v. Wade*. In effect they argue that the use of D & E makes abortion through the 17th or 18th week of pregnancy safer than childbirth. Thus, under *Roe v. Wade*, the state's interest in maternal health does not become compelling before that time because "mortality in abortion may be less than mortality in normal childbirth." 410 U.S. at 163, 93 S.Ct. at 731. By requiring early second trimester abortions to be performed in a more expensive and less convenient setting than out-patient clinics, they contend the state has impermissibly burdened the con-

stitutional rights of pregnant women seeking such abortions. Since there is no compelling state interest at stake before that time, the plaintiffs assert that a regulation requiring abortions to be performed in a hospital prior to the 17th or 18th week of pregnancy does not meet the constitutional requirement that it be narrowly drawn so as to relate only to the state's legitimate interest.

There was an abundance of evidence that D & E is the safest method of performing post-first trimester abortions today. Two qualified physicians testified that it is safe to perform D & E abortions in an out-patient clinic through the 17th or 18th week of pregnancy. One of these witnesses stated that the plaintiff Akron Women's Clinic is adequately equipped and staffed to perform early second trimester abortions. The defendants presented an expert medical witness with unchallenged qualifications who recognized that abortion is "not a static situation" and that there is support for the opinion that early second trimester abortions may be performed safely outside of hospitals. Nevertheless, this witness stated that this proposition "is not clearly established." Furthermore, he testified that the American College of Obstetricians and Gynecologists has made no change in its 1973 recommendation that second trimester abortions be performed only in hospitals.

Evidence of the burden imposed by the requirement of section 1870.03 related to two factors. There was unrebutted testimony that there were only two hospitals in Akron in which second trimester abortions were being performed. During the year preceding trial, only nine such abortions were performed in these two hospitals. It was testified that approximately 10% of the 6,000 women who sought abortions at the Akron clinics during the same period were in their second trimester of pregnancy. Many of these women were referred to clinics in Cleveland, Ohio and in the State of Michigan. Those who were unable to travel to those places were faced with the choice of carrying the baby to term, attempting self-abortion or seeking illegal abortions. The mortality and morbidity incidence of self-abortions and illegal abortions greatly exceeds that of the second trimester D & E procedure. The second burdensome feature of the in-hospital requirement is the cost. It was testified that a second trimester abortion in a hospital costs $850–$900, while total charges for a D & E abortion in a clinic are $350–$400.

The plaintiffs argue that the effect of section 1870.03 is to make second trimester abortions completely unavailable for many women who desire them. Many pregnant women, especially the very young, do not seek an abortion until they have entered the second trimester. Without the ability to travel and the funds to pay for hospital treatment, many of these Akron women have no real opportunity to obtain an abortion.

In its first ruling the district court held that the plaintiffs did not have standing to challenge section 1870.03. However, upon reconsideration the court concluded that the plaintiffs did have standing, and it addressed the merits of the respective positions of the parties. Referring to the decision in *Roe v. Wade*, the district court stated:

> The Court further recognized that the state had a valid interest in maternal health and the protection of potential human life. The state's interest in potential human life was found to become "compelling" at viability. The state's interest in protecting maternal health, "in the light of present medical knowledge," was found to become "compelling" at approximately the end of the first trimester. *Roe, supra* [410 U.S.] at 163, 93 S.Ct. at 731. Section 1870.03 was passed in furtherance of this asserted compelling state interest in protecting maternal health from the close of the first trimester of pregnancy.

479 F.Supp. at 1215.

It then concluded:

> Plaintiffs' attack Section 1870.03 saying that although abortions beyond the end of the first trimester of pregnancy

were safer in a hospital setting at the time of the *Roe* decision, that is no longer true. Plaintiffs presented evidence in the form of testimony and exhibits to support a finding that early second trimester clinical abortions are now just as safe as early second trimester hospital abortions. The Court, however, does not find plaintiffs' evidence on this issue so convincing that it is willing to discard the Supreme Court's formulation in *Roe*. Accordingly, the Court finds that Section 1870.03 furthers the compelling state interest in protection of maternal health and is, therefore, constitutional.

Id.

At least two district courts have recently determined that the state's interest in the health of a pregnant woman does not become compelling until the 18th week of pregnancy. *Margaret S. v. Edwards, supra; Planned Parenthood Association of Kansas City v. Ashcroft, supra.* Both holdings were based on findings that widespread use of the D & E method represents a medical advance which makes abortion during early weeks of the second trimester sufficiently safe to eliminate maternal health as a basis for state interference. In each case the district court also found that no hospital in the region was performing post-first trimester abortions. The unavailability of in-hospital D & E abortions in the area resulted in pregnant women and their physicians being forced to use a more dangerous method, in the view of these courts. Both courts relied upon the fact that a ban on the use of the saline instillation method, which resulted in a similar denial of access to abortions, was held unconstitutional in *Planned Parenthood of Missouri v. Danforth, supra.*

The rationale of these decisions appears persuasive. However, the Supreme Court has now affirmed a 3-judge district court decision which found a provision identical to § 1870.03 constitutional. *Gary-Northwest Indiana Women's Services, Inc. v. Bowen,* 496 F.Supp. 894, 896–902 (N.D.Ind.1980), *aff'd sub nom. Gary-Northwest Indiana Women's Services, Inc. v. Orr,* —— U.S. ——, 101 S.Ct. 2012, 68 L.Ed.2d 321 (1981). Many of the same arguments for holding the requirement that all second trimester abortions be performed in a hospital unconstitutional which were made in the present case were made by the plaintiffs in *Gary-Northwest.* Though the evidence on this issue in the present case was more detailed than that produced in *Gary-Northwest,* the thrust of the plaintiffs' proof and argument was the same. The Supreme Court has now had an opportunity to retreat from the "bright line" drawn in *Roe v. Wade* and has declined to do so. The district court's holding that section 1870.03 is constitutional is affirmed.

V. Standing

A.

[10] The district court held that none of the plaintiffs had standing to contest section 1870.04 which forbids abortions after viability except to prevent the death or impairment of the health of the pregnant woman. None of the plaintiffs performed abortions after the first trimester and the district court denied permission to a pregnant woman and an Akron doctor who did perform post-first trimester abortions to proceed under pseudonyms. The plaintiffs argue that these persons would have had standing to attack section 1870.04 if they had been permitted to proceed. On the record before us we cannot say it was an abuse of discretion to deny the requests to proceed by pseudonym.

[11] A more serious challenge to the standing ruling is contained in the contention of the plaintiffs that the physician-plaintiff should have been granted *jus tertii* standing to represent pregnant women who desire abortions after viability, but who were not before the court. The plaintiffs rely principally upon *Singleton v. Wulff,* 428 U.S. 106, 96 S.Ct. 2868, 49 L.Ed.2d 826 (1976), where two doctors were found to have standing to assert the rights of their patients. In *Singleton* the doctors sought a holding that a statute which denied Medicaid benefits for non-medically indicated abortions was unconstitutional. The physician-plaintiffs were actually performing abortions for needy patients and were being

denied payment for their services because of the statutory provision in question. In upholding the claim of standing, the Court made two distinct findings—that the plaintiff-doctors suffered "concrete injury" from operation of the statute, *Id.* at 113, 96 S.Ct. at 2873–74, and because of the close relationship between them and their patients, the doctors were "uniquely qualified" to test the statute on behalf of their patients. *Id.* at 117, 96 S.Ct. at 2875–76. Though the plaintiff-doctor in the present case might see and counsel women who desire an abortion after viability, it is clear that he would not perform the abortion.

The district court recognized the principle of *jus tertii* standing:

> Cases involving *jus tertii* (the right of a third party) standing can generally be divided into two categories. The first involves litigants who challenge legislation which imposes regulations upon them and, as a result of the regulations imposed, allegedly deprives third parties of constitutional rights. The second category involves litigants who suffer injury because regulations allegedly impairing constitutional rights of third parties are imposed directly on those third parties whose rights the litigants seek to assert. This case is within the first category. That is, plaintiffs allege that regulations imposed directly on them violate rights guaranteed their patients. Such plaintiffs "have been uniformly permitted to resist efforts at restricting their operations by acting as advocates of the rights of third parties who seek access to their market or function."

479 F.Supp. at 1184 (citations omitted). However, denial of such standing to the plaintiff-physician was properly based upon the fact that he had never even expressed a desire to perform a post-viability abortion. Thus, this plaintiff suffered "no injury in fact" from the operation of section 1870.04. Failing to meet this requirement, the plaintiff did not have "a sufficiently concrete interest in the outcome" of this action to make it a case or controversy under Article III of the Constitution. *Singleton v. Wulff*, *supra*, 428 U.S. at 112, 96 S.Ct. at 2873 (plurality opinion). *See also*, concurring opinion of Mr. Justice Stevens, 428 U.S. at 121, 96 S.Ct. at 2877. Lacking such interest in the outcome, he did not have standing to assert the claims of others despite his claimed "close relationship" with women whom he counseled and whose rights he was seeking to protect. The holding of the district court that no party demonstrated standing to challenge the constitutionality of section 1870.04 is affirmed.

B.

[12] The defendants dispute the standing of Dr. Bliss, the physician-plaintiff who remained in the case. Dr. Bliss does not reside in Akron, but has performed first trimester abortions at one of the plaintiff-clinics. He testified that he expected to continue to do so. The district court correctly held that Dr. Bliss has standing as a plaintiff in this case.

VI. Disposal of Remains

[13] With respect to section 1870.16, relating to disposal of fetus remains, we agree with the district court that the language is impermissibly vague as definition of a criminal act. The City defendants have urged us to void only the word "humane," arguing that the words "in a . . . sanitary manner" are sufficiently clear. If the City desires to legislate on this subject it should do so either by enacting specific requirements or by referring to regulations which set forth the requirements with specificity. The possibility that the language of section 1870.16 might be construed to mandate some sort of "decent burial" of an embryo at the earliest stages of formation is too real to be overlooked. The district court correctly found section 1870.16 invalid on grounds of vagueness.

The judgment of the district court is affirmed in part and reversed in part. No costs allowed.

CORNELIA G. KENNEDY, Circuit Judge. Concurring in part and dissenting in part.

I respectfully dissent from part II (standard of review), that portion of IIIA relat-

ing to minors under 15, and a portion of IIIB of the majority's opinion.

The District Court ruled that abortion regulations that do not absolutely prohibit or afford the power to veto a woman's decision to have an abortion may withstand constitutional scrutiny though furthering something less than a "compelling" state interest. It held that regulations that interfere with a woman's privacy to a lesser degree may be weighed against any valid state interests furthered by the regulation. The majority, rejecting the District Court's standard, would apply a two-step test. First, if the provision in question causes no "legally significant" impact on the right of a pregnant woman to choose to terminate her pregnancy, it is constitutional. Second, if it causes a legally significant impact, the provision must be supported by a compelling state interest and must be sufficiently narrowly drawn so as not to unduly burden the woman's right. Because I am less certain than the majority that the Supreme Court's abortion decisions call for such a two-step analysis, I am not able to concur with the panel even th[illegible]h I do not completely agree with the District Court either.

Because there appears to have been some shift on the issue in the Supreme Court's decisions a lengthy and detailed review of its cases is required. Language from the earliest abortion decisions supports the majority's conclusion that only a compelling state interest will justify significant first trimester abortion regulation. In *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), the Court spoke broadly in invalidating a statute that absolutely prohibited abortions except to save the life of the mother:

> Where certain "fundamental rights" are involved, the Court has held that regulation limiting these rights may be justified only by a "compelling state interest" . . . and that legislative enactments must be narrowly drawn to express only the legitimate state interest at stake.

Id. at 155, 93 S.Ct. at 728 (citations omitted).

> [Because the interest in material health becomes compelling at the end of the first trimester], [i]t follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation relates to the preservation and protection of maternal health. . . . This means, on the other hand, that, for the period of pregnancy prior to this "compelling" point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated.

Id. at 163, 93 S.Ct. at 732.

> Up to [this point], the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.[1]

Id. at 166, 93 S.Ct. at 733.

In the next case, *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976), the Court appears to be ambivalent as to the proper standard of review, though the case signals at least some retreat from the broad language of *Roe*. In relevant part the Court held that Missouri could not give an absolute veto over a woman's abortion decision to the woman's spouse or parents. However, Missouri could impose record keeping requirements on an abortion clinic that it did not impose for other surgical procedures; the record keeping requirement did not have a "legally significant" impact on the abortion decision or the physician-patient relationship. *Id.* at 81, 96 S.Ct. at 2846.[2] Thus far *Planned Parent-*

1. The Supreme Court did not use the word "significant" to distinguish permissible and impermissible first trimester regulation in *Roe v. Wade*. Indeed, the Court's language prohibited *all* first trimester abortion regulation. However, even in *Roe* the Court, without explanation, permitted a state to proscribe any abortion not performed by a physician. 410 U.S. at 165, 93 S.Ct. at 733.

2. This is apparently the basis for the threshold requirement of "legal significance" in the majority's test. However, because the term "legally significant" as used by the Supreme

hood is consistent with both the District Court's and the majority's test.

In the course of its opinion in *Planned Parenthood* the Court quoted language from *Roe v. Wade* that can be used to support the majority's test:

> "For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician," without interference from the State.

Id. at 61, 96 S.Ct. at 2837.[3]

On the other hand, the Court held that Missouri could require that the woman consent in writing to the abortion procedure, though such a requirement was not imposed for other types of surgery, because "[t]he decision to abort, indeed, is an important, and often a stressful one . . . ." *Id.* at 67, 96 S.Ct. at 2840. It is possible that such a consent requirement is "legally insignificant," or "furthers a compelling state interest," and the Supreme Court's holding is therefore consistent with the standard developed by the majority. However, the Court did not analyze the requirement in this way. Indeed, in *Bellotti v. Baird*, 428 U.S. 132, 147, 96 S.Ct. 2857, 2866, 49 L.Ed.2d 844 (1976) (*Bellotti I*), the Court stated that *Planned Parenthood* held the consent requirement constitutional because it did not "unduly burden" the right to seek an abortion.

At issue in *Bellotti I* was the constitutionality of a Massachusetts statute requiring parental consent to abortions for unmarried minors. The Supreme Court remanded the case so the district court could get an authoritative construction of the statute from the Massachusetts Supreme Judicial Court. The Supreme Court stated that it did not need to determine the point at which review of a woman's consent or of good cause for an abortion in the case of a minor becomes "unduly burdensome," 428 U.S. at 148, 96 S.Ct. at 2866, or whether a court hearing to determine whether informed consent was given would "unduly burden" the rights of an adult. *Id.* at 147, 96 S.Ct. at 2866. No mention is made in *Bellotti I* of any compelling state interest. Again, the facts of *Bellotti I* do not militate against either the majority's or the District Court's standard. However, the Supreme Court's language indicates that the panel's formulation is incorrect.

Maher v. Roe, 432 U.S. 464, 97 S.Ct. 2376, 53 L.Ed.2d 484 (1977), held that the Constitution does not require states to fund nontherapeutic abortions. The Supreme Court observed that the court below had read *Roe v. Wade* and progeny

> as establishing a fundamental right to abortion and therefore concluded that nothing less than a compelling state interest would justify Connecticut's different treatment of abortion and childbirth. We think the District Court misconceived the nature and scope of the fundamental right recognized in *Roe*. . . . We held [in *Roe*] that only a compelling state interest would justify such a sweeping restriction on a constitutionally protected interest, and we found no such state interest during the first trimester. . . . In subsequent cases, we have invalidated other types of restrictions different in form but similar in effect, on the woman's freedom

Court did no more than state a conclusion, it is not helpful in *reaching* a conclusion.

3. The Court recently quoted from *Roe* to the same effect in invalidating a statute which required a certain abortion technique where the fetus "may be viable":

> . . . up to the points where important state interests provide compelling justifications for intervention, "the abortion decision in all its aspects is inherently, and primarily, a medical decision" . . . .

Colautti v. Franklin, 439 U.S. 379, 387, 99 S.Ct. 675, 681, 58 L.Ed.2d 596 (1979).

Insofar as this language suggests that no regulation of abortion is permitted before the end of the first trimester absent a compelling justification, it supports the majority's standard. However, since the purpose of *Colautti* was to emphasize the central role of the physician in the abortion decision, and other Supreme Court cases, *infra*, indicate that *Roe* did not prohibit all such first trimester regulation, the quote is entitled to little weight on the issue of the standard of review.

> of choice.... Although a state-created obstacle need not be absolute to be impermissible ... we have held that a requirement for a lawful abortion "is not unconstitutional unless it *unduly burdens* the right to seek an abortion." ... As *Whalen* [*v. Roe*, 429 U.S. 589, 599–600, 97 S.Ct. 869, 876–877, 51 L.Ed.2d 64] makes clear, the right in *Roe* can be understood only by considering both the woman's interest and the nature of the State's interference with it. *Roe* did not declare an unqualified "constitutional right to an abortion," as the District Court seems to think. Rather, the right protects the woman from *unduly burdensome* interference with her freedom to decide to terminate her pregnancy.

Id. at 472–474, 97 S.Ct. at 2382 (citations omitted) (emphasis added).

The Court also upheld Connecticut's requirement that a woman who sought state funding for a therapeutic abortion submit her request in writing and get the prior approval of the Connecticut Department of Social Services. *Id.* at 480, 97 S.Ct. at 2386. The Court found the requirement reasonable although there was no similar requirement for other forms of surgery because "such [other] procedures do not involve the termination of a potential human life." *Id.*

The majority distinguishes *Maher* by pointing out the Supreme Court's emphasis that the case did not involve limitations on the right to an abortion. While true, this means only that the *facts* of *Maher*, like the *facts* of *Roe v. Wade*, *Planned Parenthood*, and *Bellotti I*, do not determine the correct standard. The majority also attaches significance to language in *Maher* in which the Supreme Court states that its "conclusion signals no retreat from *Roe* or the cases applying it." *Id.* at 475, 97 S.Ct. at 2383. The majority interprets this as signalling "that the [Supreme Court's] later cases do not represent a retreat from the *Roe v. Wade* holding that the state's right to regulate abortions, at each stage of pregnancy, must rest on a compelling and legitimate state interest." However, when the Court in *Maher* announced that it was not retreating from *Roe*, it meant only that it was not retreating from *Roe* as it had interpreted *Roe* in the preceding pages of its opinion in *Maher*, that is, to forbid "unduly burdensome" regulation of abortions.

In *Bellotti v. Baird*, 443 U.S. 622, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979) (*Bellotti II*), the Court struck down a Massachusetts statute requiring parental consent to abortions for mature minors. The four-justice plurality framed the issue thus:

> The question before us—in light of what we have said in the prior cases—is whether [the statute], as authoritatively interpreted by the Supreme Judicial Court, provides for parental notice and consent in a manner that does not *unduly burden* the right to seek an abortion.

Id. at 640, 99 S.Ct. at 3046 (emphasis added).

The plurality concluded that as construed the statute

> would impose an *undue burden* upon the exercise by minors of the right to seek an abortion.... [U]nder state regulation such as that undertaken by Massachusetts, every minor must have the opportunity—if she so desires—to go directly to a court without first consulting or notifying her parents.

Id. at 647, 99 S.Ct. at 3050 (emphasis added).

The plurality added that "the constitutional right to seek an abortion may not be *unduly burdened* by state-imposed conditions upon initial access to court." *Id.* at 648, 99 S.Ct. at 3051 (emphasis added).

The requirement of either going to court or notifying one's parents is clearly a significant burden. Therefore, to be consistent with the panel's analysis the Supreme Court should have found a compelling state interest before inquiring whether the statute would unduly burden the right to seek an abortion. The plurality found the state's interest in encouraging a family resolution of a minor's abortion decision "important." *Id.* at 648, 99 S.Ct. at 3051. It never found

the state's interest compelling.[4] Thus, while the result in *Bellotti II* may be consistent with the standard of review suggested by the panel the plurality's analysis is not.

Harris v. McRae, — U.S. —, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980), upheld as constitutional the Hyde Amendment, which forbade the use of federal funds for abortions. The Court stated:

> The doctrine of *Roe v. Wade*, the Court held in *Maher*, "protects the woman from *unduly burdensome* interference with her freedom to decide whether to terminate her pregnancy," *id.* [432 U.S.], at 473–474 [97 S.Ct. at 2382–83], such as the severe criminal sanctions at issue in *Roe v. Wade, supra*, or the absolute requirement of spousal consent for an abortion challenged in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 [96 S.Ct. 2831, 49 L.Ed.2d 788].

Id. — U.S. at —, 100 S.Ct. at 2686 (emphasis added).

Again, the Supreme Court's language indicates that the panel's formulation is incorrect.

The most recent case to deal with abortions is *H. L. v. Matheson*, — U.S. —, 101 S.Ct. 1164, 67 L.Ed.2d 388 (1981), where the Court held constitutional a requirement that unmarried, immature minors under the age of 15 notify their parents of their decision to seek an abortion. The Court observed that the statute did not involve an absolute veto, and that it served "important considerations" and "significant state interests." *Id.* — U.S. at —, 101 S.Ct. at 1173–74. The Court did not engage in the two-step analysis suggested by the panel.

Thus, the Supreme Court has never suggested the analysis put forth by the majority. It has sometimes suggested that a compelling state interest is necessary to justify any state regulation of abortion during the first trimester, but that language has always been far broader than required by the facts before it. With the exception of the passage in *Colautti, supra*, and a part of *Planned Parenthood*, all of the cases since *Roe* have suggested that the proper standard is simply whether a regulation that does not effectively prohibit abortions is "unduly burdensome" to the decision whether or not to abort. The Court's decisions are all consistent with that standard. Although this standard is very close to that applied by the District Court, it differs in that the District Court required that the prohibition or veto be absolute before it must be justified by a compelling state interest.[5]

My resolution of the remaining issues, however, does not depend on whether I apply the majority's standard, that of the District Court, or what I perceive to be the Supreme Court's position.

Section 1870.05(B) requires for a minor under the age of 15 either consent of a parent or "an order from a court having jurisdiction over her that the abortion be performed or induced" as a condition of terminating pregnancy. The District Court invalidated section 1870.05(B) because it did

4. It may be argued that the Court simply applies a different standard of review in the case of minors. However, the Court has not said that it does, and it is not clear why the standard of review, rather than the relative weights of the parties' interests, should change. The state's interests in the case of minors are weightier, and thus lead to a different outcome in the balancing process.

5. *Charles v. Carey*, 627 F.2d 772, 777–778 (7th Cir. 1980), is not persuasive support for the majority's decision. The district court in that case held that a law that unduly burdens the abortion decision is subject to strict scrutiny. The Seventh Circuit held that "the term 'undue burden' defines the ultimate constitutional issue, not merely the threshold requirement for strict scrutiny." *Id.* at 777. With this statement I agree. I do not take the additional step of subjecting all regulations of abortion that are not *de minimis* to the compelling state interest standard.

The Seventh Circuit's concern that plaintiffs who must challenge abortion regulations on other than an across-the-board "compelling state interest" standard will be unable to anticipate the state's possible justifications for the regulations simply does not ring true in the abortion context. Nor do I share the Seventh Circuit's concern that the courts are incapable of determining when a burden on the abortion decision is "undue."

not protect the abortion decision of a mature minor, and the majority affirms this decision. The District Court, however, made no attempt to construe section 1870.05(B) in a constitutional fashion.

In *H. L. v. Matheson* the Utah statute required a minor's physician "to notify, if possible, the parents or guardian of the woman upon whom the abortion is to be performed, if she is a minor...." —— U.S. at ——, 101 S.Ct. at 1166–67. In an unrelated case the federal district court in Utah had held that this statute did not apply to unemancipated minors. *L. R. v. Hansen*, Civil No. C–80–0078J (Feb. 8, 1980). Because the minor who brought suit in *Matheson* did not show that she was mature or emancipated, she lacked standing to challenge the statute as applied to such minors, and the Supreme Court was "unwilling to assume that the statute, when challenged in a proper case, will not be construed also to exempt demonstrably mature minors." —— U.S. at ——, 101 S.Ct. at 1169.

Similarly, in *Bellotti I*, the Supreme Court remanded for authoritative construction a statute that required parental consent to abortions for minors. "[I]n light of our disapproval of a 'parental veto' today in *Planned Parenthood*, we must assume that the lower Massachusetts courts, if called upon to enforce the statute pending interpretation by the Supreme Judicial Court, will not impose this most serious barrier." 428 U.S. at 151, 96 S.Ct. at 2868.

Section 1870.05(B) is capable of a construction that would render it constitutional. This would be the case if, for example, the order from "a court having jurisdiction" was based, as it constitutionally must be, first on an inquiry into the minor's maturity. Thus, the section is not facially invalid. As the majority notes in reversing the District Court's holding that section 1870.05(A) is unconstitutional, no minor challenges the Akron ordinance. I would not find section 1870.05(B) unconstitutional until a mature minor challenges it and until it has been construed by a lower court.

I also dissent from that portion of the panel's opinion which reverses the holding of the District Court that § 1870.06(C) is constitutional. This section requires that the attending physician advise the patient of

> the particular risks associated with her own pregnancy and the abortion technique to be employed including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery, and shall in addition provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or to carry her pregnancy to term.

The majority holds that this provision infringes on the medical judgment of the attending physician. The section does not, however, interfere with the patient's right to decide whether to terminate her pregnancy. *Cf. Colautti v. Franklin*, 439 U.S. at 392–394, 396, 99 S.Ct. at 684–85, 686 (1979); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. at 64, 96 S.Ct. at 2839; *Roe v. Wade*, *supra*. Further, the witnesses who testified at trial agreed that the information should be given to the patient. Indeed, in *Planned Parenthood v. Danforth*, the Court stated that "[t]he decision to abort is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." 428 U.S. at 67, 96 S.Ct. at 2840. The Court considered that informed consent meant

> the giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession.

Id. n. 8. The Utah statute at issue in *H. L. v. Matheson* provided that no abortion could be performed

> unless a "voluntary and written consent" is first obtained by the attending physician from the patient. In order for such a consent to be "voluntary and informed," the patient must be advised at a

minimum about available adoption services, about fetal development, and about foreseeable complications and risks of an abortion.

—— U.S. at —— n. 1, 101 S.Ct. at 1167 n. 1. In upholding this requirement, the Supreme Court simply noted that in *Planned Parenthood v. Danforth* "we rejected a constitutional attack on written consent provisions." *Id.* Thus, the Supreme Court apparently does not believe that the limited information required by .06(C) imposes an undue burden on the physician. The giving of such information enhances, rather than restricts, the woman's freedom of choice. "Informed consent" without this information would be worthless. *See also Wolfe v. Schroering*, 541 F.2d 523, 526 (6th Cir. 1976).

Plaintiffs' objection is not to the giving of the information, but rather to the requirement that the information be given by a physician. The Supreme Court has repeatedly recognized the importance of the physician-patient relationship to the abortion decision. Several times the Court has stated that during the first trimester the physician, in consultation with his patient, must be free to determine that in his medical judgment the patient's pregnancy should be terminated. *Bellotti II*, 443 U.S. at 641 n. 21, 643, 99 S.Ct. at 3047, n. 21, 3048; *Colautti v. Franklin*, 439 U.S. at 387, 99 S.Ct. at 681; *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. at 61, 96 S.Ct. at 2837; *Roe v. Wade*, 410 U.S. at 163, 164, 93 S.Ct. at 732. In *Planned Parenthood* the Court emphasized "participation by the attending physician [in the abortion decision] and his responsibility in that decision . . . ." 428 U.S. at 61, 96 S.Ct. at 2837. In *Roe*, the Court would have permitted a state to require that abortions be performed by a licensed physician, which at least strongly implies the state's interest in ensuring the existence of a physician-patient relationship. 410 U.S. at 165, 93 S.Ct. at 732–733. As the Court observed in *Colautti*, "*Roe* stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out." 439 U.S. at 387, 99 S.Ct. at 681.

The requirement that the information specified in .06(C) be given by a physician does no more than seek to ensure that there is in fact a true physician-patient relationship even for the woman who goes to an abortion clinic. The evidence presented at trial showed that the decision to terminate a pregnancy was made not by the woman in conjunction with her physician, but by the woman and lay employees of the abortion clinic, the income of which is dependent upon the woman's choosing to have an abortion. The testimony disclosed that the doctors at Akron Center's clinic did little, if any, counseling before seeing the patient in the procedure room. Akron's ordinance simply takes into account these realities of the "physician-patient" relationship at an abortion clinic.

I concur in the majority's conclusion that the 24-hour delay imposed by § 1870.07 is unconstitutional. However, the state has a strong interest in ensuring a carefully considered abortion decision, the 24-hour delay is substantially related to that state interest, and in many instances the delay imposes no undue burden on the right to an abortion. Nonetheless, .07 as it now stands is overbroad. For example, it would require a 24-hour delay even where the delay would impose a grave risk to the mental health of the pregnant woman, where the woman has already been counseled by a physician, or where the delay would cause such significant extra expense to an individual as to unduly burden if not effectively prohibit the decision. The Supreme Court requires closer attention to the circumstances of individual cases in the abortion context. *Bellotti II*, 443 U.S. at 643, n. 23, 99 S.Ct. at 3048, n. 23.

I concur in the balance of the majority's opinion.

The GARY-NORTHWEST INDIANA WOMEN'S SERVICES, INC.; William R. Lewis, M. D.; Jane Doe; Mary Roe; Brigette Coe; and all others similarly situated, Plaintiffs,

v.

Otis BOWEN, Governor of the State of Indiana; Henry Kowalczyk, Lake County Prosecutor; Indiana State Board of Health; William T. Paynter, M. D., State Health Commissioner and the Executive Officer of the Indiana State Board of Health; Theodore Sendak, Attorney General of the State of Indiana; Their Agents, Assigns, Successors, Representatives, Those acting in concert with them, and all others similarly situated, Defendants.

No. H 74-289.

United States District Court,
N. D. Indiana,
South Bend Division.

Sept. 12, 1980.

Action was brought challenging constitutionality of certain provisions of Indiana's abortion statute. A three-judge panel of the United States District Court for the Northern District of Indiana, 421 F.Supp. 734, granted plaintiffs certain permanent injunctive relief, which was affirmed by the United States Supreme Court, 429 U.S. 1067, 97 S.Ct. 799, 50 L.Ed.2d 785. Upon plaintiffs' motion for modification of the previously entered final judgment, the District Court, Allen Sharp, J., held that: (1) it was reasonable for Indiana to conclude that

second trimester hospitalization requirement would promote maternal health and therefore portion of its abortion statute requiring hospitalization for all second trimester abortions was constitutional, and (2) even if plaintiffs' legal theory was accurate, they failed to justify a preliminary injunction.

Request for relief from final judgment denied.

1. Federal Courts ⇐992

Although statutory section governing three-judge district courts was repealed, jurisdiction over constitutional challenge to Indiana's abortion statute, which was filed at time when statute was in effect, rested with three-judge panel. 28 U.S.C.A. § 2281 (Repealed 1976).

2. Constitutional Law ⇐42.1(3)

Criminal statute regulating abortions may be challenged in federal court by persons who otherwise have standing if they are not presently being prosecuted.

3. Federal Courts ⇐47

Inasmuch as criminal action against operator of abortion clinic had been dismissed, federal court would not abstain from ruling on operator's motion to modify a final order refusing to rule unconstitutional a provision of Indiana's abortion statute requiring hospitalization for all second trimester abortions. Fed.Rules Civ.Proc. Rule 60, 28 U.S.C.A.; IC 35-1-58.5-1 et seq. (1976 Ed.).

4. Abortion and Birth Control ⇐1.30

Ultimate test for determining constitutionality of statutes regulating second trimester abortions is not whether statute has statistically demonstrated result of decreasing maternal morbidity or mortality for specific groups of abortions but, rather, is whether legislature acted reasonably in determining that regulation would promote maternal health.

5. Abortion and Birth Control ⇐1.30

Statistics used to determine reasonableness of statute regulating second trimester abortions must be statistics not for a specific group of abortions but for all the abortions to which regulation applies.

6. Abortion and Birth Control ⇐1.30

It was reasonable for Indiana to conclude that second trimester hospitalization requirement would promote maternal health and therefore portion of its abortion statute requiring hospitalization for all second trimester abortions was constitutional. IC 35-1-58.5-1 et seq. (1976 Ed.).

7. Injunction ⇐147

Even assuming accuracy of legal theory of plaintiffs, who challenged constitutionality of portion of Indiana abortion statute requiring hospitalization for all second trimester abortions on behalf of women in their second trimester of pregnancy who would allegedly be denied opportunity to terminate their pregnancies if challenged portions of statute were not invalidated, plaintiffs, who did not produce sufficient evidence to demonstrate the likelihood in proving birth more dangerous than an early second trimester D and E abortion, failed to justify a preliminary injunction.

W. Henry Walker, East Chicago, Ind., Julian B. Wilkins, Jenner & Block, Chicago, Ill., for plaintiffs.

Theodore L. Sendak, Atty. Gen., Darrel K. Diamon, Asst. Atty. Gen., Indianapolis, Ind., Jack Crawford, Lake County Prosecutor, Crown Point, Ind., for defendants.

Before SPRECHER, Circuit Judge, and ESCHBACH, and SHARP, District Judges.

MEMORANDUM AND ORDER

ALLEN SHARP, District Judge.

[1] An abortion clinic, its operator, and certain pregnant women brought this class action challenging the constitutionality of certain provisions of the Indiana abortion statute, IC 35-1-58.5. This action was originally filed on November 13, 1974. A

three-judge district court was convened pursuant to 28 U.S.C. § 2281.[1]

This Court granted the plaintiffs certain preliminary injunctive relief on January 31, 1975: *Gary-Northwest Indiana Women's Services, Inc., v. Bowen*, 418 F.Supp. 9. This Court granted the plaintiffs certain permanent injunctive relief on September 14, 1976: *Gary-Northwest Indiana Women's Services, Inc., v. Bowen*, 421 F.Supp. 734. That final order was affirmed by the Supreme Court of the United States on January 25, 1977: *Bowen v. Gary-Northwest Indiana Women's Services, Inc.*, 429 U.S. 1067, 97 S.Ct. 799, 50 L.Ed.2d 785. The case then lay dormant until February 21, 1980, when the plaintiffs filed a petition for a hearing on the application of Mary Roe[2] for preliminary and permanent injunctive relief against the enforcement of the Indiana abortion statute's hospitalization requirement for all second trimester abortions. An evidentiary hearing was held before Judge Allen Sharp on April 23, 1980. The parties were given time to file supplemental briefs. Judge Sharp referred all matters and issues to all the judges of the panel for consideration and determination.

The plaintiffs are requesting a modification of this Court's previously entered final judgment. In the first order, granting preliminary relief, this Court declined to hold Indiana's hospitalization requirement unconstitutional. In the final order granting permanent relief, this Court declined to modify its previous refusal to rule Indiana's hospitalization requirement unconstitutional. The plaintiffs are requesting this Court to modify its final order and hold the hospitalization requirement unconstitutional.

Modifications of final orders are governed by Fed.R.Civ.P. 60. The plaintiffs request relief from the final judgment on the basis of evidence proving that only one hospital in Indiana will allow non-therapeutic second trimester abortions and evidence proving that childbirth is more dangerous to a mother's health than certain second trimester abortions.

Even if the plaintiffs' evidence proved the plaintiffs' allegations, this Court's prior ruling would remain unaffected. Accordingly, the requested relief from final judgment will be denied.

I.

[2, 3] Before reaching the substantive issues of the plaintiffs' petition, an abstention argument must be considered. Both the state attorney general and the Lake County prosecutor have argued that under *Younger v. Harris*, 401 U.S. 37, 91 S.Ct. 746, 27 L.Ed.2d 669 (1971), this Court should abstain from this case in order to avoid interfering with the state prosecution of the plaintiff William R. Lewis, M.D., operator of the plaintiff abortion clinic. On February 21, 1980, when the plaintiffs first requested the preliminary and permanent injunctive relief, the plaintiff Dr. Lewis was being prosecuted for violating the Indiana abortion statute. See Plaintiff's Reply Brief filed April 18, 1980. But, before the April 23, 1980, evidentiary hearing, the criminal action against Dr. Lewis had been dismissed. Tr. 7. A criminal statute regulating abortions may be challenged in federal court by persons who otherwise have standing if they are not presently being prosecuted. See *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973). Neither Dr. Lewis nor any other plaintiff is presently being prosecuted. Abstention does not apply to this case.

II.

A.

The plaintiffs' argument is as follows: (1) Only one Indiana hospital, the Methodist

1. This section has since been repealed. Jurisdiction over this case nonetheless rests in a three-judge panel because this section was in effect as of the date the complaint was filed. *BT Investment Managers, Inc., v. Lewis*, 559 F.2d 950 (5th Cir. 1977), *Calabi v. Malloy*, 438 F.Supp. 1165 (D.Vt.1977), Act of Aug. 12, 1976, Pub.L.No. 94-381, § 7.

2. The Mary Roe seeking injunctive relief is apparently a class member and not the named plaintiff Mary Roe. See Transcript of Hearing on Plaintiffs' Petition, April 23, 1980, at 65 (hereinafter cited as Tr. —).

Hospital of Gary, Inc., located in Gary, Indiana, will allow the use of its facilities for the performance of non-therapeutic second trimester abortions; (2) Some indigent women cannot afford the expense of traveling to the Gary Methodist Hospital for the purpose of acquiring a non-therapeutic abortion; (3) Indiana's requirement that all second trimester abortions be performed in a hospital therefore requires some indigent women to bear a child rather than acquire a non-therapeutic second trimester abortion; (4) Childbirth is more dangerous to a mother's health than a second trimester abortion, if the abortion is performed during approximately the first half of the second trimester of pregnancy, and if the dilation and evacuation (D & E) method is used; (5) Therefore, Indiana's hospitalization requirement forces some indigent women to pursue a course of action which is more dangerous to their health than the course of action which they would pursue in the absence of Indiana's hospitalization requirement; (6) Therefore, Indiana's hospitalization requirement does not "reasonably relate to maternal health" and is accordingly unconstitutional. See *Roe v. Wade*, 410 U.S. 113, 164, 93 S.Ct. 705, 732, 35 L.Ed.2d 147 (1973).

In *Roe*, the Supreme Court of the United States summarized the relevant portions of its ruling as follows:

> (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
>
> (c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."

410 U.S. at 164-65, 93 S.Ct. at 732.

The plaintiffs argue that for purposes of determining the constitutionality of regulations, the second trimester must now be divided into two approximately equal time periods. The earlier of these periods is the thirteenth through the eighteenth week of pregnancy. The later of these periods is the nineteenth through the twenty-fourth week of pregnancy.[3]

The plaintiffs do not argue that a hospitalization requirement applying only to late second trimester abortions would be unconstitutional. It is clear that throughout nearly all of the late second trimester, *Roe* holds that a state's only compelling interest is in protecting maternal health. Under *Roe* it is only when the child becomes viable that the state's interest in protecting the child's life becomes compelling. Most children reach viability, given present medical technology, sometime near the twenty-fourth week.[4] Nonetheless, the plaintiffs

3. It is not clear from the record the exact point at which the plaintiffs believe the second trimester should be divided. However, the plaintiffs' argument is based solely on improvement in the D & E abortion technique. The plaintiff doctor testified that he would not perform D & E abortions as late as the twenty-first week, but that he would perform D & E abortions through the sixteenth week. Tr. 57, 71, 78. Certain statistics introduced indicated that D & E abortions have been performed as late as the twenty-first week. Tr. 78. The eighteenth week is used as a cutoff here because that is the cutoff used in the two district court cases which adopted the plaintiffs' theory. The ultimate ruling in this case renders the specific cutoff irrelevant.

4. Seven years ago, in *Roe*, the Supreme Court noted that current technology made a child viable sometime between the twenty-fourth and twenty eighth week. 410 U.S. at 160, 93 S.Ct. at 730. Some of the plaintiffs' argument seems to imply an attack on Indiana's use of the word "viability". It seems that the plaintiff is arguing that for each specific child the point of viability is so difficult to determine that a state criminal statute using the term is unconstitutionally vague. See Plaintiffs' Supplemental Brief filed May 19, 1980, at page 2. A child's viability is determined by many factors besides the child's prenatal age, including, among other factors, the availability of medical technology capable of providing the child with substitutes for the functions performed by the

agree that *Roe* would allow a hospitalization requirement for abortions performed during the late second trimester because the dangers to the mother are great enough to render a hospitalization requirement reasonably related to maternal health.[5] There is no dispute about the constitutionality of a hospitalization requirement for late second trimester abortions.

The plaintiffs argue only that the hospitalization requirement is unconstitutional when applied to certain early second trimester abortions. Throughout the earlier half of the second trimester, the fetus is clearly not viable, given present medical technology. (Assuming continued progress is our technical ability to provide substitutes for the mother's womb, it is not altogether inconceivable that viability, and a state's compelling interest in preserving the child's life, may well at some future time reach into this time period.) For the present, *Roe* means that a state's only compelling interest during the early second trimester is in maternal health. The plaintiffs argue that a hospitalization requirement applying to certain early second trimester abortions is unconstitutional.

The plaintiffs do not argue that a hospitalization requirement applying only to early second trimester abortion techniques other than D & E would be unconstitutional. The plaintiffs agree that for procedures other than D & E a hospitalization requirement reasonably relates to maternal health. Tr. 22–23. The plaintiffs argue only that certain early second trimester D & E abortions are so safe that applying Indiana's hospitalization to them does not reasonably relate to maternal health.

Furthermore, the plaintiffs' argument may not apply to therapeutic abortions. The plaintiffs appear to argue not that the hospitalization requirement is unconstitutional on its face, but that it is unconstitutional because hospitals are unavailable. Hospitals are available for therapeutic abortions. See Tr. 74–75 and Defendant's Exhibit A. The plaintiffs' argument may apply only to non-therapeutic early second trimester D & E abortions.

Finally, the plaintiffs' argument may not apply to pregnant women financially capable of traveling to the Gary Methodist Hospital to acquire an abortion. The plaintiffs appear to argue that Indiana's hospitalization requirement denies abortions to only certain indigent women, indigent women financially unable to travel to the Gary Methodist Hospital.

The plaintiffs' constitutional arguments seem to apply only to non-therapeutic early second trimester D & E abortions desired by indigent women financially unable to travel to the Gary Methodist Hospital.[6] The plaintiffs argue that since Indiana's hospitalization requirement applies to these abortions, the hospitalization requirement is unconstitutionally overbroad. See Plaintiffs' Supplemental Brief filed May 19, 1980 at page 2.

B.

To adopt the plaintiffs argument would require this Court to controvert the express language of *Roe*. With regard to second trimester abortions, the Supreme Court of the United States said:

> With respect to the State's important and legitimate interest in the health of the

womb of the child's mother. If this Court were writing on a clean slate, this Court might give serious attention to this argument. However, in *Roe* the Supreme Court of the United States has encouraged, perhaps even required, the use of the term in statutes regulating abortions. This Court could not rule that the Supreme Court of the United States has encouraged the use of an unconstitutionally vague term.

5. See footnote 3, supra.

6. It should be noted here that the plaintiffs have presented no evidence that there is, in Indiana, a pregnant woman (1) financially unable to travel to the Gary Methodist Hospital who desires a (2) non therapeutic (3) early second trimester (4) D & E abortion. Even the plaintiff, Mary Roe, on whose behalf the plaintiff's latest petition has been made, fails to satisfy the criteria since she is a patient of Dr. Lewis, which implies that she is financially able to travel to Gary and the Gary Methodist Hospital, since Dr. Lewis practices medicine in Gary.

mother, the "compelling" point, in light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now-established medical fact, referred to above at 725 [93 S.Ct. at 724], that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. *Examples of permissible state regulation in this area are requirements* as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; *as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status*; as to the licensing of the facility; and the like.

* * * * * *

To summarize and to repeat:

* * * * * *

For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.

410 U.S. at 163–64, 73 S.Ct. at 732 (emphasis added).

The language is clear. A hospitalization requirement for second trimester abortions is constitutional. Indiana and many other states have relied on this interpretation of the language. This Court has "an obligation to follow the precedents of our highest Court." *Gary-Northwest Indiana Women's Services v. Bowen*, 421 F.Supp. 734, 736 (N.D.Ind.1976) (separate statement of Judge Sharp in an earlier decision in this action.) This Court is bound by the language of *Roe*. This Court may not controvert specific rulings of the Supreme Court of the United States. The express language of *Roe* mandates that Indiana's second trimester hospitalization requirement be found by this Court to be constitutional.

Several cases have interpreted *Roe* to mean that a second trimester hospitalization requirement is constitutional: *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976); *Akron Center for Reproductive Health, Inc., v. City of Akron*, 479 F.Supp. 1172 (N.D.Ohio 1979); *Westchester Women's Health Organization, Inc., v. Whalen*, 475 F.Supp. 734 (S.D.N.Y.1979); and *Wynn v. Scott*, 449 F.Supp. 1302 (N.D.Ill.1978), *affirmed sub nom., Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979). These cases relied generally on the statement in *Roe* that a second trimester hospitalization requirement is constitutionally permissible. Two very recent cases have interpreted *Roe* to mean that a second trimester hospitalization requirement is unconstitutional: *Margaret S. v. Edwards*, 488 F.Supp. 181 (E.D.La.1980), and *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 483 F.Supp. 679 (W.D.Mo.1980). The plaintiffs rely on these recent cases.

To adopt the plaintiffs' theory and hold Indiana's hospitalization requirement unconstitutional because of its impact on non-therapeutic early second trimester D & E abortions would ultimately require that the second trimester be split for purposes of determining the constitutionality of regulations. Such a holding would require states to adopt, for their maternal health regulations, some cutoff other than the end of the first trimester. The *Roe* language clearly demonstrates the intent of the Supreme Court to encourage, indeed force, states to use the end of the first trimester as a cutoff point for regulations designed to protect maternal health. That is precisely what Indiana and many other states have done. *Roe* implied that states would not be required to treat one portion of the second trimester different from another portion of the second trimester. *Roe* implied that it was proper for states to adopt regulations dealing with the entire second trimester. If a general regulation of second trimester abortions protects maternal health, then, *Roe* holds, the regulation is constitutional,

notwithstanding its impact on a specific second trimester abortion or a specific group of second trimester abortions.

The plaintiffs' argument could be construed as an argument that the *Roe* test to be applied to early second trimester D & E abortions is not the second trimester test, but the first trimester test. This argument could be stated as follows: *Roe* allows regulation not of second trimester abortions, but only of abortions more dangerous than childbirth. This seems to be the theory underlying the two District Court cases supporting the plaintiffs' argument. The specific ultimate rulings in *Roe* with regard to the various stages of pregnancy were somewhat arbitrary judgments necessitated by a wide variety of factors. This Court must respect *Roe*'s specific ultimate rulings. If this Court does not respect the specific ultimate rulings in *Roe*, those rulings will lose their usefulness. If the line which the Supreme Court drew at the end of the first trimester is not respected, states will be hard pressed to pursue their legitimate, compelling, interests in protecting maternal health. If a regulation is covered by *Roe*, the regulation's constitutionality is determined on the basis of the specific lines drawn by the Supreme Court.

If the plaintiffs' theory was adopted, then the states might still be able to remain within constitutional parameters by repealing their current maternal health regulations and enacting regulations applying not to abortions performed "after the first trimester," but to abortions performed "in such a manner and at such a time that they are more dangerous than childbirth." If the Supreme Court had intended the test for determining whether a state could regulate a specific abortion to be the safety of the abortion relative to childbirth, the Supreme Court would have so stated the test. The Supreme Court did not so state the test. The Supreme Court stated the test to be the chronological stage of the pregnancy. Under *Roe*, a maternal health regulation may take effect at the end of the first trimester. If the constitutionality of the regulation depended on whether, as a matter of fact, an abortion was more dangerous than childbirth, then it must be remembered that each individual pregnancy raises its own set of facts. The safety of a given abortion, the safety of a given childbirth, and the relative safety of an abortion *vis a vis* childbirth in a given pregnancy, all depend on a multitude of medical factors which vary with each and every pregnancy. Such a rule would have the potential of making the constitutionality of each specific application of a regulation depend to a large degree on the factors present in that specific case. If the Supreme Court had intended that complicated medical judgment be decisive on whether specific regulations were reasonably related to maternal health, then the Supreme Court would surely have instead adopted the more rational rule that the abortion's effectuation must be left to the medical judgment of the pregnant woman's attending physician. That was the rule adopted for first trimester abortions. It was the intent of the Supreme Court to allow states to regulate second trimester abortions as a group, and *Roe* holds that as long as the regulation is reasonably related to the maternal health of women in the second trimester of their pregnancy, the regulation is constitutional.

The plaintiffs' argument could also be construed as an argument that Indiana's hospitalization requirement is subject not to the first trimester test, but to the second trimester test, but that the hospitalization requirement does not satisfy the second trimester test. This argument would be applicable exclusively to the regulation as applied to women financially incapable of traveling to the Gary Methodist Hospital. The argument would be that the regulation effectively prevents these women from obtaining an abortion which is less dangerous than childbirth, and that the regulation is therefore not rationally related to maternal health. While the Supreme Court held in *Roe* that states may not constitutionally prohibit certain abortions, the Supreme Court has since held that states are not required to guarantee the practical availability of abortions to indigent women. It follows that in regulating second trimester

abortions, Indiana is not required to guarantee the availability of abortions to indigent women. As long as the regulation is reasonably related to Indiana's compelling interest in protecting maternal health, the regulation is constitutional, without regard to the regulation's practical impact on the availability of abortions to indigent women. In *Maher v. Roe*, 432 U.S. 464, 97 S.Ct. 2376, 53 L.Ed.2d 484 (1977), the Supreme Court held that it was constitutional for Connecticut to prevent the use of its welfare benefits for non-therapeutic abortions. The Supreme Court said:

> The indigency that may make it difficult–and in some cases, perhaps, impossible–for some women to have abortions is neither created nor in any way affected by the Connecticut regulation. We conclude that the Connecticut regulation does not impinge upon the fundamental right recognized in *Roe*.

432 U.S. at 474, 97 S.Ct. at 2383. The latest Supreme Court abortion cases are the companion cases *Harris v. McRae*, — U.S. —, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980), and *Williams v. Zbaraz*, — U.S. —, 100 S.Ct. 2694, 65 L.Ed.2d 831 (1980), which apply the *Maher v. Roe* reasoning to the refusal by both the federal and state governments to fund certain abortions which were therapeutic. In *Harris v. McRae*, the Supreme Court said:

> [A]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category. The financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortions, but rather of her indigency.

— U.S. at —, 100 S.Ct. at 2688. The background of *Harris v. McRae* is that the government had been paying welfare benefits for both childbirth and abortions, and the so-called Hyde Amendment prohibited the use of welfare benefits for abortions. The Supreme Court ruled that the combination of the Hyde Amendment and pregnant women's indigency did not render unconstitutional this pursuit of the government's legitimate, though not compelling, interest in encouraging childbirth over abortion. The obstacle which the indigent women faced was not the Hyde Amendment, but the women's indigency. The interest in Indiana is pursuing in its hospitalization requirement is the protection of maternal health, an interest not only legitimate, but compelling. The *Harris v. McRae* reasoning applies *a fortiori* to Indiana's hospitalization requirement. The combination of the hospitalization requirement and the pregnant women's indigency does not render unconstitutional this pursuit of Indiana's legitimate, compelling, interest in protecting maternal health. The obstacle which the women face is not the hospitalization requirement, but the women's indigency. The indigency that may make it difficult–and in some cases, perhaps, impossible–for some women to have abortions is neither created nor in any way affected by the Indiana regulation. The Indiana regulation does not impinge upon the fundamental right recognized in *Roe*.

It would be impractical for the constitutionality of a second trimester regulation to depend on a factual question, such as whether the regulation in fact reduced maternal morbidity and mortality. Interpreting *Roe* to require that second trimester regulations except specific types of abortions which may be safer than childbirth would require relitigation of the regulation's constitutionality with each change in the availability of abortions, with each improvement in abortion technique, and with each publication of statistics showing that abortion skills had improved. Such an interpretation of *Roe* would result in repeated relitigation of the constitutionality of the same statute. It is the policy of the Supreme Court to avoid, if possible, the creation of rules of law which increase litigation. *Roe* should not be given an interpretation which results in repeated relitigation of a statute's constitutionality. *Roe* does not render the constitutionality of second trimester regulations subject to either the

availability of abortions or the improvements in medical techniques and skills.

[4, 5] The test for determining the constitutionality of statutes regulating second trimester abortions is not whether the statute has the statistically demonstrable result of decreasing maternal morbidity or mortality for specific groups of abortions. Whether, as a matter of fact, it is statistically demonstrable that the regulation results in decreased maternal morbidity and mortality is a matter to be considered, but it is not the ultimate test. The ultimate test is a broader test: whether the legislature acted reasonably in determining that the regulation would promote maternal health. Furthermore, the statistics used to determine the reasonableness of a regulation would have to be the statistics not for a specific group of abortions, but for all the abortions to which the regulation applies. A statutory regulation of second trimester abortions is constitutional if it was reasonable for the state to conclude that the regulation would promote maternal health.

C.

[6] It was reasonable for Indiana to conclude that the second trimester hospitalization requirement would promote maternal health.

Clearly, it is reasonable for a state to conclude that a hospitalization requirement will promote health. It cannot be seriously disputed that medical risks accompany abortions. It is therefore eminently reasonable to require that abortion be performed in a hospital. Hospitalization may be the most obviously reasonable health-related regulation that there is.[7] That is probably why the Supreme Court of the United States expressly stated that hospitalization would be a regulation reasonably related to maternal health. Indiana's determination that a hospitalization requirement would promote maternal health can be supported by reason. The statutory hospitalization requirement is reasonably related to maternal health. Accordingly, the statutory hospitalization requirement is constitutional. That was this Court's previous judgment in this case. A contrary ruling would controvert *Roe*.

III.

Even if the plaintiffs' legal theory was accurate, the plaintiffs would have failed to justify a preliminary injunction.

While this Court would be required to consider all relevant factors in deciding whether to exercise its discretion in favor of granting a preliminary injunction, the traditional standard for granting a preliminary injunction requires the petitioner to show (1) irreparable injury and (2) a likelihood of success on the merits. *Doran v. Salem Inn, Inc.*, 422 U.S. 922, 95 S.Ct. 2561, 45 L.Ed.2d 648 (1975); *National Tank Truck Carriers, Inc. v. Burke*, 608 F.2d 819 (1st Cir. 1979); *Butler v. Goldblatt Bros., Inc.*, 589 F.2d 323 (7th Cir. 1978); *Washington v. Walker*, 529 F.2d 1062 (7th Cir. 1976).

[7] The pregnant women present a clear case of potential irreparable injury. The petition for a preliminary injunction is brought on behalf of women in their second trimester of pregnancy who will allegedly be denied the opportunity to terminate their pregnancies if the challenged portions of the Indiana abortion statute are not held unconstitutional. A pregnancy unterminated will result in a child born, a result which is hardly reclaimable, hardly reparable. And since *Roe* holds that a fundamental right of privacy includes a fundamental right to an abortion, the birth of an unwanted child must be construed as irreparable "injury."

On the other hand, even if the plaintiffs' legal theory was accurate, they have failed to demonstrate a likelihood of success on the merits. There was presented no evidence sufficient to convince this Court that

7. Three Supreme Court Justices have even suggested that *Roe* might allow states to require hospitalization for first trimester abortions. *Sendak v. Arnold*, 429 U.S. 968, 97 S.Ct. 476, 50 L.Ed.2d 579 (1976) (Dissent by Justice White, with whom Chief Justice Burger and Justice Rehnquist joined.)

birth is more dangerous than early second trimester D & E abortions. The plaintiff, Dr. Lewis, testified that, in his opinion, a second trimester hospitalization requirement does not reasonably relate to maternal health. Tr. 61. He briefly elaborated on the basis of that opinion. Tr. 62–63. There was some somewhat confusing testimony by Dr. Lewis that the complication rate (a rate including both morbidity and mortality) was either 5.38/100 or 5.88/100 for D & E abortions performed from the thirteenth to the fifteenth week. Tr. 68–69. No comparable statistics for childbirth were given. Dr. Lewis testified that for the United States in 1972–1976 the D & E mortality rate was 7.6/100,000 for the thirteenth to fifteenth week and 13.2/100,000 for the sixteenth to twentieth week. Tr. 78. Defendant's Exhibit B is an affidavit of the Director of the Public Health Records Division of the Indiana State Board of Health, in which the Director states that the Indiana maternal death rate was 7.0/100,000 in 1977 and 10.8/100,000 in 1978. Dr. Lewis testified that the D & E current morbidity rates were lower than those for 1972–1976 because of improved medical practices. Tr. 77. To conclude on the basis of this evidence that early second trimester D & E abortions are safer than childbirth would require this Court to grant Dr. Lewis more credibility than this Court believes he deserves. Dr. Lewis is a plaintiff in this case with a significant pecuniary interest in the outcome. The evidence produced at the hearing was insufficient to persuade this Court that the plaintiff would likely succeed in proving birth more dangerous than an early second trimester D & E abortion.

Thus, even if the plaintiffs' legal theory was accurate, the plaintiffs would have failed to justify a preliminary injunction.

CONCLUSION

For the reasons stated in Part II, above, this Court's prior final judgment would be unaffected even if the plaintiffs could prove birth more dangerous than early second trimester D & E abortions. Accordingly, the plaintiffs' request for relief from the final judgment heretofore entered in this case is DENIED.

Document #18

MARGARET S., on her own behalf and on behalf of all others similarly situated; Dr. Roy Wood, Dr. Calvin Jackson, and Dr. Duncan McKellar, on their own behalf and on behalf of all others similarly situated; and Clinical Leasing Services, Inc., d/b/a Delta Women's Clinic, Orleans Women's Clinic and Causeway Medical Suite

v.

Edwin W. EDWARDS, Governor of the State of Louisiana; William J. Guste, Jr., Attorney General of the State of Louisiana; William Cherry, M.D., Secretary of the State of Louisiana Health and Human Resources Administration; all of the above in their individual and official capacities.

Civ. A. No. 78-2765.

United States District Court,
E. D. Louisiana.

March 3, 1980.

Case was filed challenging constitutionality of Louisiana statute regulating abor-

tion. The District Court, Robert F. Collins, J., held that certain provisions of the Louisiana statute regulating abortion are unconstitutional.

Order accordingly.

1. Constitutional Law ⇐42.1(1)

Thirty-year-old single woman and mother of six children who was in second trimester of pregnancy had standing to challenge Louisiana statute regulating abortions and termination of her pregnancy did not render her case moot. LSA–R.S. 40:1299.35.1 et seq.

2. Constitutional Law ⇐42.1(1)

Medical physicians had standing to assert their own rights and the rights of their patients and challenge Louisiana statute regulating abortions. LSA–R.S. 40:1299.35.1 et seq.

3. Federal Civil Procedure ⇐103

Where issues in case challenging Louisiana statute governing abortions were adequately represented by individual plaintiff and physician plaintiff, it was unnecessary to decide whether corporate plaintiffs, certain clinics which performed abortions, had standing to sue. LSA–R.S. 40:1299.35.1 et seq.

4. Federal Civil Procedure ⇐176

Case brought challenging constitutionality of Louisiana statute regulating abortions was properly brought and certified as class action with two subclasses, one consisting of women and one consisting of physicians. LSA–R.S. 40:1299.35.1 et seq.; Fed.Rules Civ.Proc. Rule 23(b)(2), 28 U.S.C.A.

5. Abortion and Birth Control ⇐1.30

Louisiana statute regulating abortion which defines "abortion" as the deliberate termination of a human pregnancy after fertilization of a female ovum, by any person, including the pregnant woman herself with an intention other than to produce a live birth or to remove a dead unborn child is not impermissibly vague despite contention that it covers at least two methods of birth control, the intra-uterine device and the "morning-after" pill. LSA–R.S. 40:1299.35.1(1).

6. Abortion and Birth Control ⇐1.30

Restricting post-first trimester abortions to hospitals has no rational relationship to the preservation of maternal health. LSA–R.S. 40:1299.35.3.

7. Abortion and Birth Control ⇐.50

Because the dilation and evacuation method of abortion up to the 18th week of pregnancy is safer than childbirth, the state's interest in regulating abortion prior to the 18th week of pregnancy is not "compelling." LSA–R.S. 40:1299.35.3.

See publication Words and Phrases for other judicial constructions and definitions.

8. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute which requires abortions after the first trimester to be performed in a hospital, which limits access to abortion without regard to preservation of maternal health and attempts to regulate abortions prior to time when state's interest in maternal health becomes compelling, is unconstitutional. LSA–R.S. 40:1299.35.3.

9. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion which forbids abortions after a fetus becomes viable except "to prevent permanent impairment to [mother's] health" and also requires that attending physician obtain certification of one or perhaps two other doctors to confirm judgment as to both necessity for performing abortion and consequences of doing so, is an unconstitutional infringement upon a physician's right to practice. LSA–R.S. 40:1299.35.4, subd. A.

10. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion which establishes a presumption of viability for fetuses that are more than 24 weeks old is an unconstitutional infringement on a physician's right to practice medicine. LSA–R.S. 40:1299.35.4, subd. B.

11. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion which requires that once the presumption of viability exists doctors must use the abortion method most likely to preserve the fetus is void for vagueness. LSA–R.S. 40:1299.35.4, subd. C.

12. Abortion and Birth Control ⇐1.30

Although provision of Louisiana statute regulating abortion which requires that a second physician be in attendance when a fetus is aborted after viability is permissible, requirement that second physician, after the abortion, shall take all reasonable steps to preserve the life and health of the unborn child is unconstitutional in that it creates a conflict between the judgment of the two physicians. LSA–R.S. 40:1299.35.4, subd. B.

13. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion which requires any minor under age of 15 who desires abortion to obtain either written consent of her parent or guardian, or obtain order from court having jurisdiction over her permitting abortion to be performed fails to provide alternate procedure whereby authorization for abortion can be obtained and is, therefore, unconstitutional. LSA–R.S. 40:1299.35.5, subd. B.

14. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion which states that physician cannot perform abortion until he gives 24 hours actual notice or 72 hours constructive notice to a parent or legal guardian of all unmarried women under age of 18 who decide to obtain an abortion imposes an undue burden upon the exercise of the right to obtain abortion of unmarried women between the ages of 15 and 17 years. LSA–R.S. 40:1299.35.5, subd. A.

15. Physicians and Surgeons ⇐15(8)

Informed consent involves fiduciary nature of doctor-patient relationship as well as basic right of self-determination that governs potential invasions of physical integrity and its aim is to encourage awareness in patient's mind of risks associated with medical procedure and to obtain his assent to encountering those risks.

16. Physicians and Surgeons ⇐15(8)

Generally, all risks in medical procedure need not be disclosed to patient to have an informed consent.

17. Abortion and Birth Control ⇐1.30

Informed consent provision of Louisiana statute regulating abortion which requires physician to describe fetus at the gestational point of development at the time the abortion is to be performed and to state that an unborn child is a human life from the moment of conception is unconstitutional. LSA–R.S. 40:1299.35.6, subd. B, par. 3.

18. Abortion and Birth Control ⇐1.30

Informed consent provision of Louisiana statute regulating abortion which includes presumption that viability occurs 22 weeks after conception is unconstitutional because it is based on an irrebuttable presumption of viability. LSA–R.S. 40:1299.-35.6, subd. B, par. 4.

19. Abortion and Birth Control ⇐1.30

Informed consent provision of Louisiana statute regulating abortion which mandates that physicians tell patients that abortion is a major surgical procedure which can result in serious complications and that abortion may leave essentially unaffected or may worsen any existing psychological problems that mother can have and can result in severe emotional disturbances is unconstitutional since determination as to what each patient must be told must be left up to individual physician based on needs of particular patient. LSA–R.S. 40:1299.35.6, subd. B, par. 5.

20. Abortion and Birth Control ⇐1.30

Informed consent provision of Louisiana statute regulating abortion which requires physician to communicate information to patient dealing with natural and artificial birth control is unconstitutional because it is not reasonably related to purpose of informed consent. LSA–R.S. 40:1299.35.6, subd. B, par. 6.

21. Abortion and Birth Control ⇐1.30

Informed consent provisions of Louisiana statute regulating abortion which require physician to inform patient of available social services should the patient opt for childbirth instead of abortion are rationally related to the giving of an informed consent to undergo an abortion and are constitutional. LSA–R.S. 40:1299.35.6, subd. B, pars. 7, 8.

22. Abortion and Birth Control ⇐1.30

Informed consent provisions of Louisiana statute regulating abortion which require physician to provide relevant information based on his own medical judgment and require patient to sign consent form are constitutional. LSA–R.S. 40:1299.35.6, subds. C, D.

23. Abortion and Birth Control ⇐.50

Access to abortion procedure is a fundamental right and regulation limiting such right may be justified only by a compelling state interest and must be narrowly drawn.

24. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion which requires that physician must wait at least 24 hours after patient signs required informed consent form before performing abortion places significant and unconstitutional burden upon woman's ability to obtain an abortion, thus restricting the woman's constitutional right to privacy. LSA–R.S. 40:1299.35.7.

25. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion which requires that essentially all of the doctor's paper work, as well as all forms required, be kept by doctor for seven years is an unconstitutional burden on both a doctor's right to practice medicine and a woman's right to privacy. LSA–R.S. 40:1299.35.8.

26. Searches and Seizures ⇐7(1)

Provision of Louisiana statute regulating abortion which requires that both medical records and abortion facilities be open for inspection at any time by Department of Health and Human Resources and that Department must inspect all such locations at least once every six months violates the Fourth Amendment because it authorizes warrantless inspections. LSA–R.S. 40:1299.35.9; U.S.C.A.Const. Amend. 4.

27. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion that requires doctors to submit abortion report on each patient to Department of Health and Human Resources is constitutional except to the extent that it requires that doctors provide the zip code or residence of the pregnant woman. LSA–R.S. 40:1299.35.10, subd. A.

28. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion which requires an individual complication report for any postabortion care performed on a woman to be completed by a physician is rationally related to state's interest in health and is constitutional. LSA–R.S. 40:1299.35.10, subd. B.

29. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion that requires doctors to sign their abortion and complication reports is constitutional. LSA–R.S. 40:1299.35.10, subd. C.

30. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion stating that no person shall experiment upon or sell a live child or unborn child unless such experimentation is therapeutic to the child or unborn child is rationally related to the promotion of a legitimate state interest and is constitutional. LSA–R.S. 40:1299.35.13.

31. Abortion and Birth Control ⇐1.30

Provision of Louisiana statute regulating abortion stating that a physician who performs an abortion shall insure that the remains of the unborn child are disposed of in a manner consistent with disposal of other human remains as provided by statute is an unconstitutional exercise of state's police power, because it requires that fetal remains be treated with same dignity as remains of a person and, thereby, unduly burdens the right of a woman to obtain an

ab•rtion and represents an impermissible attempt of the state to influence woman's abortion decision. LSA–R.S. 40:1299.35.14.

32. Abortion and Birth Control ⇐1.30

Provisions of Louisiana statute regulating abortion which require that all abortion facilities shall be licensed by Louisiana Department of Health and Human Resources and which sets forth detailed standards for licensing, requiring that each abortion facility have specified drugs and equipment on hand, are unconstitutional because they impose restrictions upon woman's right to obtain an abortion prior to period when state's interest in maternal health becomes compelling. LSA–R.S. 40:1299.35.16, 40:1299.35.-17.

33. Abortion and Birth Control ⇐1.30
Constitutional Law ⇐84

Louisiana statute regulating abortion did not constitute an establishment of religion in violation of First Amendment of United States Constitution. LSA–R.S. 40:1299.35.1 et seq.; U.S.C.A.Const. Amend. 1.

George M. Strickler, New Orleans, La., Judith Levin, Janet Benshoof, New York City, Wayne G. Hawley, Cleveland, Ohio, John Wilson Reed, New Orleans, La., Stephen Landsman, Cleveland, Ohio, for plaintiffs.

Michael R. Connelly, Baton Rouge, La., Louis M. Jones, Ronald Davis, New Orleans, La., for defendants.

Sidney M. Bach, New Orleans, La., for intervenor Dr. Okpalobi.

Lane Carson, New Orleans, La., James Bopp, Jr., Indianapolis, Ind., Robert E. Winn, New Orleans, La., for intervenors Dr. Moorman, Carr, Gaudin & Richey, amici curiae.

Nadine Taub, Newark, N. J., for American Public Health, amicus curiae.

Leo Pfeffer, New York City, for American Humanist Ass'n, amicus curiae.

OPINION

ROBERT F. COLLINS, District Judge.

This case presents a constitutional challenge to a recently enacted Louisiana statute regulating abortion. La.Rev.Stat.Ann. §§ 40:1299.35.1 *et seq.* (West Supp.1979). In approaching the issues presented in this case, this Court thinks that the following quotation from the landmark decision of *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973) is relevant:

> We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion.
>
> In addition, population growth, pollution, poverty, and racial overtones tend to complicate and not to simplify the problem.
>
> Our task, of course, is to resolve the issue by constitutional measurement, free of emotion and of predilection.

Roe, 410 U.S. at 116, 93 S.Ct. at 708–09.

This Court earnestly seeks to accomplish this task. In pursuing this quest, the Court is bound by decisions of the United States Supreme Court and the jurisprudence which has evolved in this area.

I.

Margaret S.,[1] a single resident of New Orleans, Louisiana, brought suit in August, 1978 on behalf of herself and all those similarly situated seeking declaratory and in-

1. The name is a pseudonym. By agreement of counsel, Margaret S. was dismissed from the suit on October 18, 1978 because of her refusal to be deposed. By further agreement of counsel, Margaret S. II was substituted as plaintiff in an amended complaint filed November 6, 1978.

junctive relief against the operation of a Louisiana abortion statute, La.Rev.Stat. Ann. §§ 40:1299.35.1 *et seq.* (West Supp. 1979) (the Act). As a single, pregnant woman desirous of obtaining an abortion, Margaret S. alleged that the statute deprived her of fundamental constitutional rights, including her right to due process of law, equal protection, privacy, and the free exercise of religion, in violation of the First, Fourth, Fifth, Ninth, and Fourteenth Amendments to the Constitution.

Dr. Roy C. Wood, Dr. Calvin Jackson, and Dr. Duncan McKellar, physicians licensed to practice in Louisiana, sued to represent all present and future Louisiana physicians who "desire to give full, safe, and adequate medical advice and treatment to their patients" but who allegedly would be restricted in their medical practice and threatened with criminal prosecution under the Act. They allege that the Act is vague, overbroad, a denial of equal protection and due process of law, and violative of their rights under the First, Ninth, and Fourteenth Amendments.

Delta Women's Clinic (Delta), with locations in both New Orleans and Baton Rouge, and Orleans Women's Clinic offer gynecological services that include sterilization, first trimester abortions, and abortions subsequent to the first trimester. Causeway Medical Suite offers similar services, but does not perform abortions after the first trimester. All allege that the Act, by "subject[ing] . . . facilities which provide abortion services to regulation and criminal prosecution should they fail to comply with any of the [Act's] provisions," deprives them of their right to privacy and to due process of law under the Constitution of the United States.

Dr. T. C. A. Okpalobi, d/b/a Gentilly Medical Clinic for Women (Gentilly), filed suit September 6, 1978 as a plaintiff-intervenor. After adopting all the claims set out in the original complaint, he focuses on La.Rev.Stat.Ann. §§ 40:1299.35.9, .10 (West Supp.1979). He alleges that these sections violate his right to equal protection and due process of law and that they conflict with La.Rev.Stat.Ann. § 15:476 (West 1967) because of their intrusive effect upon traditional patient-physician confidentiality.

On January 8, 1979, the Court certified this suit as a class action, with Margaret S. II and Dr. Roy C. Wood as named representatives of their respective classes.[2] Trial was held in October and November, 1978. Final arguments were heard December 13, 1978. Final post-trial briefs were filed March 5, 1979.

II.

Jurisdiction in this case is founded on 28 U.S.C. § 1331(a) (1976)[3] and 28 U.S.C. § 1343(3) (1976).[4]

2. The classes were defined as follows: Class A, represented by Margaret S. II, consists of "all women in Louisiana capable of bearing children who are now or may become pregnant and who desire or may desire an abortion to be performed in Louisiana by the physician of their choice." Order of January 8, 1979. Class B, represented by Dr. Roy C. Wood, was defined as "all Louisiana physicians who desire or may desire to give full, safe, adequate and responsible medical advice and treatment to their patients, including the performance of abortions, but who have been or will be prevented from doing so because of the restrictions of [La.Rev.Stat.Ann. §§ 40:1299.35.1 *et seq.* (West Supp.1979)] and defendants' actions thereunder." Gentilly Complaint, ¶ III. (A), (B), (C).

3. Jurisdiction pursuant to 28 U.S.C. § 1331 exists when "the matter in controversy exceeds the sum or value of $10,000, exclusive of interest and costs, and arises under the Constitution, laws or treaties of the United States." Plaintiffs' complaints allege that the matter in controversy exceeds $10,000. "An allegation in the complaint of the requisite amount will normally suffice to confer jurisdiction upon the court if the claim is made in good faith and unless it appears to a legal certainty that the claim cannot be satisfied." *Lister v. Commissioners Court*, 566 F.2d 490, 492 (5th Cir. 1978) (citation omitted); 14 Wright, Miller & Cooper, *Federal Practice and Procedure* § 3702 at 372 73 (Federal Practice). "Nevertheless, the law is plain that a controversy must be capable of money valuation in order to satisfy the jurisdictional amount requirement . . . . The inherent value alone of a constitutional right is insufficient to satisfy the jurisdictional amount requirement . . . ." *Lister*, 566 F.2d at 493 (citations omitted). *See also City of Milwau-*

4. See note 4 on p. 187.

III.

Two threshold issues must be addressed: "[f]irst, whether the plaintiff[s] allege 'injury in fact,' that is, a sufficiently concrete interest in the outcome of their suit to make it a case or controversy subject to a federal court's Article III jurisdiction, and, second, whether, as a prudential matter, the plaintiff[s] are proper proponents of the particular legal rights on which they base their suit." *Singleton v. Wulff*, 428 U.S. 106, 112, 96 S.Ct. 2868, 2873, 49 L.Ed.2d 826 (1976). The Court must decide whether each class or group of plaintiffs satisfies this criteria.

A.

[1] Margaret S. II: Margaret S. II, a thirty year old single woman and a mother of six children, intervened as a party plaintiff during her second trimester of pregnancy. She stated that she could not obtain and could not afford to obtain an abortion in a hospital. As a single, pregnant woman, Margaret S. II had a concrete interest in challenging the Act. *Roe v. Wade*, 410 U.S. 113, 124–25, 93 S.Ct. 705, 712–13, 35 L.Ed.2d 147 (1973) (*Doe*). Almost every section of the Act would affect either her decision to obtain an abortion or her ability to do so. The Court holds that Margaret S. II has standing to pursue this litigation, that she presents a justiciable controversy, and that the termination of her pregnancy has not rendered her case moot. *Roe*, 410 U.S. at 125, 93 S.Ct. at 712.

B.

[2] Dr. Roy Wood, Dr. Calvin Jackson, Dr. Duncan McKellar, and Dr. T. C. A. Okpalobi: All four physicians present a justiciable controversy and have standing to sue on their own behalf:

> The physician is the one against whom these criminal statutes directly operate in the event he procures an abortion that does not meet the statutory exceptions and conditions. The physician-appellants, therefore, assert a sufficiently direct threat of personal detriment. They should not be required to await and undergo a criminal prosecution as the sole means of seeking relief.

kee v. Saxbe, 546 F.2d 693, 702–3 (7th Cir. 1976) (5th Amendment); *Kucinich v. Forbes*, 432 F.Supp. 1101, 1108 n.9 (N.D.Ohio 1977) (1st Amendment). This plain language precludes the Court from adopting one of the routes devised by other courts for circumventing the jurisdictional amount requirement, that of looking at indirect economic effects of alleged civil rights violations, holding civil and constitutional rights to be inherently worth more than $10,000, or "requiring less certainty as to the amount in controversy when substantial rights are at stake . . . ." Federal Practice § 3709 at 492–93.

However, the doctors and clinics have claimed that their right "to practice medicine in their best medical judgment" has also been infringed. *Complaint*, ¶ VI. (27). There was testimony that fear of violating the statute would cause doctors to cease doing some kinds of abortions at some stages of pregnancy. In addition, the clinics made claims of financial hardship because of the cost of complying with the regulations. Both allege the threat of criminal sanctions, which could result in fines, and, for the doctors, imprisonment and a loss of their licenses. Although the Court refused to allow the defendants to inquire into the financial records of any of the plaintiffs, "[i]n actions seeking declaratory or injunctive relief, it is well established that the amount in controversy is measured by the value of the object of the litigation." *Hunt v. Washington State Apple Advertising Commission*, 432 U.S. 333, 347, 97 S.Ct. 2434, 2443, 53 L.Ed.2d 382 (1977). The object for the doctors and clinics, in addition to the protection of their constitutional rights, is the preservation of their economic livelihood. It is not clear "to a legal certainty" that the livelihood of any individual doctor or clinic is worth less than $10,000. *St. Paul Mercury Indemnity Co. v. Red Cab Co.*, 303 U.S. 283, 289, 58 S.Ct. 586, 590, 82 L.Ed. 845 (1938). The Court, therefore, does have jurisdiction under 28 U.S.C. § 1331(a) (1976) over the claims of plaintiff doctors and clinics.

4. The jurisdictional basis for plaintiffs' claims under 42 U.S.C. § 1983 is 28 U.S.C. § 1343(3) (1976), which provides in pertinent part:

> The district courts shall have original jurisdiction of any civil action authorized by law to be commenced by any person:
>
> . . .
>
> (3) To redress the deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States . . .

Doe v. Bolton, 410 U.S. 179, 188, 93 S.Ct. 739, 745, 35 L.Ed.2d 201 (1973) (*Doe*).[5] The physicians also have an "individual economic and liberty interest . . . [in the] right to practice medicine free from the imposition of arbitrary restraints . . . ." *Greco v. Orange Memorial Hospital Corp.*, 513 F.2d 873, 875 (5th Cir.), *cert. denied*, 423 U.S. 1000, 96 S.Ct. 433, 46 L.Ed.2d 376 (1975). Furthermore, they have standing to assert the rights of their patients, such as Margaret S. II. *See Singleton v. Wulff*, 428 U.S. 106, 113–18, 96 S.Ct. 2868, 2873–76, 49 L.Ed.2d 826 (1976). *See also Griswold v. Connecticut*, 381 U.S. 479, 481, 85 S.Ct. 1678, 1679, 14 L.Ed.2d 510 (1965) (stressing confidentiality and the professional relationship).

C.

[3] Delta Women's Clinic, Orleans Women's Clinic, and Causeway Medical Suite: The clinics present a justiciable controversy since they, as well as the physicians, are threatened with criminal sanctions for failure to comply with certain provisions of the Act.[6] They may also suffer certain financial injuries.[7] There is some debate, however, as to whether the clinics also have standing to assert their patients' claims. These corporate-plaintiffs "are another step removed."[8] It is arguable that the corporate-plaintiffs do not share the confidential relationship with their *clients* that the doctors they employ share with their *patients*. Since the issues in this case are adequately represented by Margaret S. II and the physicians, the Court finds it unnecessary[9] to decide whether the corporate-plaintiffs have standing to sue.[10]

IV.

[4] The Court has certified this case as a class action pursuant to Fed.R.Civ.P. 23. Two subclasses were identified, one of women and one of physicians, whose respective representatives are Margaret S. II and Dr. Roy C. Wood.[11] Because the original order was conditional, the Court now affirms its conclusion that this suit was properly brought and certified under Fed.R. Civ.P. 23(b)(2).

V.

In *Roe*, the Supreme Court concluded that the right to privacy is "broad enough to encompass a woman's decision whether or not to terminate her pregnancy." *Roe*, 410 U.S. at 153, 93 S.Ct. at 727. The constitutional right of privacy,[12] "founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon State

5. *See also Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 62, 96 S.Ct. 2831, 2837, 49 L.Ed.2d 788 (1976) (*Danforth*); *Roe v. Ferguson*, 515 F.2d 279, 281 (6th Cir. 1975); *Nyberg v. City of Virginia*, 495 F.2d 1342, 1344 (8th Cir. 1974); *Wynn v. Scott*, 449 F.Supp. 1302, 1309 (N.D.Ill.1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979) (*Wynn*).

6. *See* cases cited at n.5 *supra*; *see also Mahoning Women's Center v. Hunter*, 444 F.Supp. 12, 15 (N.D.Ohio 1977).

7. *See Mobile Women's Medical Clinic, Inc. v. Board of Commissioners*, 426 F.Supp. 331, 334 (S.D.Ala.1977).

8. *Doe v. Bolton*, 410 U.S. 179, 189, 93 S.Ct. 739, 746, 35 L.Ed.2d 201 (1973) (*Doe*).

9. *See Danforth*, 428 U.S. at 62 n.2, 96 S.Ct. at 2838 n.2; *Doe*, 410 U.S. at 189, 93 S.Ct. at 746.

10. *Compare Singleton v. Wulff*, 428 U.S. 106, 122–31, 96 S.Ct. 2868, 2878–82, 49 L.Ed.2d 826 (1976) (Powell, J., dissenting) (decision holding that physicians have standing to assert right of third parties is "difficult to cabin") and *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F.Supp. 554, 562 (E.D.Pa.1975), *aff'd sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed.2d 1205 (1976) (*Fitzpatrick*) *with Carey v. Population Services Int'l*, 431 U.S. 678, 682–84, 97 S.Ct. 2010, 2014–15, 52 L.Ed.2d 675 (1977) and *Planned Parenthood v. Citizens for Community Action*, 558 F.2d 861, 865 n.3 (8th Cir. 1977) and *Fitzgerald v. Porter Memorial Hospital*, 523 F.2d 716, 721 n.23 (7th Cir. 1975).

11. *See* n.2, *supra*.

12. Congress has also recognized a "right to privacy" that is "a personal and fundamental right protected by the Constitution of the United States." Privacy Act of 1974, 5 U.S.C. § 552a (West 1977). *See also* Alaska Const., Art. I, § 22.

action,"[13] involves "at least two different kinds of interests . . . [:] the individual interest in avoiding disclosure of personal matters . . . and . . . the interest in independence in making certain kinds of important decisions." *Whalen v. Roe*, 429 U.S. 589, 599–600, 97 S.Ct. 869, 876, 51 L.Ed.2d 64 (1977) (footnotes omitted). *Roe v. Wade* implicitly focused on this second interest,[14] "the right of an individual to be free in action, thought, experience, and belief from governmental compulsion."[15] The Supreme Court held that this was a *fundamental* right[16] which could be limited

13. *Roe v. Wade*, 410 U.S. 113, 153, 93 S.Ct. 705, 726, 35 L.Ed.2d 147 (1973) (*Roe*).

14. The Act involves both privacy interests. *See* discussion of La.Rev.Stat.Ann. § 40:1299.35.5, .8, .9 (West Supp.1979) at text accompanying nn.75 and 102–107 *infra*.

15. *Whalen v. Roe*, 429 U.S. at 599 n.24, 97 S.Ct. at 876 n.24, *citing* Kurland, *The Private I*, The University of Chicago Magazine 7, 8 (Autumn 1976). The right of privacy is both inward looking, freedom from intrusion, and outward looking, freedom to control the information that is known about you. "Both desires are aspects of the same aspiration: to be master of the identity one creates in the world." L. Tribe, American Constitutional Law § 15-1, 888 (1978) (hereinafter cited as Tribe). *See Holmes v. Burr*, 486 F.2d 55, 67 (9th Cir.), *cert. denied* 414 U.S. 1116, 94 S.Ct. 850, 38 L.Ed.2d 744 (1973) ("The individual's interest in preserving his essential dignity as a human being") (Hufstedler, J., dissenting) (footnote omitted). *See also* A. E. Cooper, *The Physician's Dilemma: Protection of the Patient's Right to Privacy*, 22 St. Louis U.L.J. 397 (1978).

16. "[Earlier] decisions make it clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty,' . . . are included in this guarantee of personal privacy. They also make it clear that the right has some extension to activities relating to marriage, . . . procreation, . . . contraception, . . . family relationships, . . . and child rearing and education . . . ." *Roe*, 410 U.S. at 152–53, 93 S.Ct. at 726 (citations omitted). *See Alma Society, Inc. v. Mellon*, 601 F.2d 1225, 1231–33 (2nd Cir. 1979) (privacy rights of natural parents who have given their children up for adoption); *Shuman v. City of Philadelphia*, 470 F.Supp. 449, 459–60 (E.D.Pa.1979) (policemen could not be required to answer questions about personal life and sexual behavior that had no connection with job performance); *Baird v. Lynch*, 390 F.Supp. 740, 749–51 (W.D.Wis.1974) (access to contraceptive devices); *Berch v. Stahl*, 373 F.Supp. 412, 423–24 (W.D.N.C.1974) (right of imprisoned husband to communicate with wife); *Drake v. Covington County Bd. of Educ.*, 371 F.Supp. 974, 979 (M.D.Ala.1974) (unmarried teacher could not be fired for first trimester abortion); *Assoc. Stud., U. of Cal. at Riverside v. Attorney General*, 368 F.Supp. 11, 22 (C.D.Cal.1973) (access to information about contraception); *Massey v. Parker*, 362 So.2d 1195, 1199 (La.App. 4th Cir. 1978) *writ granted*, 363 So.2d 1385 (La.1978) (Schott, J., dissenting) (right to privacy of natural mother who has given up child for adoption); *State v. Saunders*, 75 N.J. 200, 381 A.2d 333 (1977) (striking state anti-fornication statute). However, the following state actions and asserted individual rights have been held not to be protected by the right of privacy: identification to the State of those individuals to whom doctors are legitimately prescribing dangerous drugs, *Whalen v. Roe*, 429 U.S. 589, 97 S.Ct. 869, 51 L.Ed.2d 64 (1977); the right of the expectant mother to have her husband present in the delivery room in a public hospital, *Fitzgerald v. Porter Memorial Hospital*, 523 F.2d 716, 721 (7th Cir. 1975); the right of an unwed mother to refuse to identify the father of her child, *Burdick v. Miech*, 385 F.Supp. 927, 929 30 (E.D.Wis. 1974), *case dismissed on abstention grounds*, 409 F.Supp. 982 (1975); consensual homosexual activity, *Doe v. Commonwealth's Atty.*, 403 F.Supp. 1199, 1200 (E.D.Va.1975), *aff'd* 425 U.S. 901, 96 S.Ct. 1489, 47 L.Ed.2d 751 (1976) (discussed in Tribe at 941–43, & 1979 Supp. at 87); the right to possess marijuana in one's own home, *Louisiana Affiliate of the Nat'l Org. for the Reform of Marijuana Laws v. Guste*, 380 F.Supp. 404, 406–7 (E.D.La.1974). Access to laetrile has sparked a number of decisions. *Compare Rutherford v. United States*, 582 F.2d 1234 (10th Cir. 1978), (access to laetrile protected), *rev'd on other grounds*, 442 U.S. 544, 99 S.Ct. 2470, 61 L.Ed.2d 68 (1979); *Rizzo v. United States*, 432 F.Supp. 356, 358 (E.D.N.Y. 1977) *with People v. Privatera*, 23 Cal.3d 697, 153 Cal.Rptr. 431, 591 P.2d 919 (1979) ("the right to obtain drugs of unproven efficiency", such as laetrile, not covered by federal or state right of privacy). *See also In Re Scott K.*, 24 Cal.3d 263, 155 Cal.Rptr. 671, 595 P.2d 105 (1979) (father could not authorize search of son's locked toolbox) (relying in part on *Carey v. Population Services Int'l*, 431 U.S. 678, 97 S.Ct. 2010, 52 L.Ed.2d 675 (1977)). *Compare United States v. Miller*, 425 U.S. 435, 96 S.Ct. 1619, 48 L.Ed.2d 71 (1976) (no protected privacy expectation in bank records) *with Commonwealth v. DeJohn*, — Pa. —, 403 A.2d 1283 (1979) and *Burrows v. Superior Court*, 13 Cal.3d 238, 118 Cal.Rptr. 166, 529 P.2d 590 (1974) (protected privacy interest in bank records).

only by compelling state interests. *Roe*, 410 U.S. at 155–56, 93 S.Ct. at 727–28.

Even though the Supreme Court determined that a woman's right to terminate her pregnancy was fundamental,[17] it rejected the argument "that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses." *Roe*, 410 U.S. at 153, 93 S.Ct. at 727. The "right is not unqualified and must be considered against important state interests in regulation." *Roe*, 410 U.S. at 154, 93 S.Ct. at 727. "The pregnant woman cannot be isolated in her privacy," for she "carries an embryo and, later, a fetus." *Roe*, 410 U.S. at 159, 93 S.Ct. at 730. "[I]t is reasonable and appropriate for a State to decide that at some point in time another interest, that of health of the mother or that of potential human life, becomes significantly involved." *Roe*, 410 U.S. at 159, 93 S.Ct. at 730. In balancing the interests of a pregnant woman with the interests of the State, the Supreme Court identified three stages of pregnancy and defined the limits of state power to regulate abortion during each of those stages:

> (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
>
> (c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

Roe, 410 U.S. at 164–65, 93 S.Ct. at 732.

With these principles in mind, the Court will consider the specific provisions of the Act which have been challenged.

VI.

DEFINITIONS: LA.REV.STAT.ANN. § 40:1299.35.1(1) (WEST SUPP.1979)

[5] The Act defines abortion as: "the deliberate termination of a human pregnancy after fertilization of a female ovum, by any person, including the pregnant woman herself with an intention other than to produce a live birth or to remove a dead unborn child." La.Rev.Stat.Ann. § 40:1299.35.1 (West Supp.1979). Plaintiffs contend that this definition is impermissibly vague[18]

17. Since *Skinner v. Oklahoma*, 316 U.S. 535, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942), wherein the Supreme Court recognized that procreation was "fundamental to the very existence and survival of the race," *Skinner*, 316 U.S. at 541, 62 S.Ct. at 1113, the Supreme Court has employed strict scrutiny analysis to review statutes affecting an individual's decision to bear children. Note that freedom over reproductive autonomy includes the entire decisional range, both the decision to bear children, *Cleveland Bd. of Ed. v. LaFleur*, 414 U.S. 632, 640, 94 S.Ct. 791, 796, 39 L.Ed.2d 52 (1974) (struck down regulations that "penaliz[ed] the pregnant teacher for deciding to bear a child"); *Skinner, supra*, as well as the decision not to bear children, *Carey v. Population Services Int'l*, 431 U.S. 678, 685, 97 S.Ct. 2010, 2016, 52 L.Ed.2d 675 (1977); *Roe, supra*; *Eisenstadt v. Baird*, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965).

18. It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined. Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application. Third, but related, where a vague statute "abuts upon sensitive areas of basic [fundamental] freedoms," it "operates to inhibit the exercise of [those] freedoms." *Uncertain meanings in-*

because it covers at least two methods of birth control, the intra-uterine device (IUD) and the "morning-after" pill. Both of these methods are deliberate attempts to terminate pregnancy after fertilization but before implantation.[19] Plaintiffs argue that the Act is ambiguous because it includes certain birth control methods not normally thought of as abortion.

> It is settled that, as a matter of due process, a criminal statute that "fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute," . . . or is so indefinite that "it encourages arbitrary and erratic arrests and convictions," is void for vagueness. . . . This appears to be especially true where the uncertainty induced by the statute threatens to inhibit the exercise of constitutionally protected rights.
>
> *Colautti v. Franklin*, 439 U.S. 596, 99 S.Ct. 675, 683, 58 L.Ed.2d 596 (1979) (citations omitted) (quoting *United States v. Harriss*, 347 U.S. 612, 617, 74 S.Ct. 808, 811, 98 L.Ed. 989 (1954) and *Papachristou v. Jacksonville*, 405 U.S. 156, 162, 92 S.Ct. 839, 843, 31 L.Ed.2d 110 (1972)).

However, the Court has been unable to discover a definition of abortion that does not suffer from the same vagueness.[20] The Act's definition, although somewhat ambiguous, would not mislead a person of ordinary intelligence. "[A] statute will not be struck down as vague even though marginal cases could be put where doubts might arise. . . . And if this general class of offenses can be made constitutionally definite by a reasonable construction of the statute, this Court is under a duty to give the statute that construction." *United States v. Harriss*, 347 U.S. 612, 618, 74 S.Ct. 808, 812, 98 L.Ed. 989 (1954). *See also Grayned v. City of Rockford*, 408 U.S. 104, 110, 92 S.Ct. 2294, 2300, 33 L.Ed.2d 222 (1972) ("Condemned to the use of words, we can never expect mathematical certainty from our language."). Abortion, as it is commonly understood, does not include the IUD, the "morning-after" pill, or, for example, birth control pills. The Court finds that the Act's definition of abortion is specific enough to give doctors, clinics, and patients "a reasonable opportunity to know what is prohibited." *Grayned*, 408 U.S. at 108, 92 S.Ct. at 2298–99.[21]

ABORTION IN HOSPITALS: LA.REV. STAT.ANN. § 40:1299.35.3 (WEST SUPP. 1979)[22]

This section states: "No person shall perform or induce an abortion upon a pregnant woman subsequent to the end of the first trimester of her pregnancy, unless such

evitably lead citizens to "'steer wider of the unlawful zone' . . . than if the boundaries of the forbidden areas were clearly marked."

Grayned v. City of Rockford, 408 U.S. 104, 108–9, 92 S.Ct. 2294, 2298–99, 33 L.Ed.2d 222 (1972) (footnotes omitted) (emphasis added).

19. See Transcript of Dr. Robert D. Crist at 6–9 (hereinafter cited as Crist Tr.).

20. The Court has examined several state statutes defining abortion. They are either similar N.D.Cent.Code § 14.02.1-02(1) (1975) ("the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead embryo or fetus"), or even broader, Del.Code tit. 11, § 654 (1975) ("an act committed . . . with intent to cause a miscarriage"), or fail to define abortion at all, Miss.Code Ann. § 97-3-3 (1972).

21. Plaintiffs have raised no objection to the Act's definition of viable: "potentially able to live outside of the womb of the mother upon premature birth whether resulting from natural causes or an abortion, or otherwise, and whether that potentially [sic] exists in part due to the provision or availability of natural or artificial life-support systems." La.Rev.Stat.Ann. § 40:-1299.35.1(3) (West Supp.1979).

Compare Danforth, 428 U.S. at 63, 96 S.Ct. at 2838; *Roe*, 410 U.S. at 160, 93 S.Ct. at 730 ("potentially able to live outside the mother's womb, albeit with artificial aid") *with Doe v. Zimmerman*, 405 F.Supp. 534, 538–39 (M.D.Pa. 1975).

22. Plaintiffs have not challenged La.Rev.Stat. Ann. § 40:1299.35.2 (West Supp.1979) which requires that abortions be done by a licensed physician. *See Connecticut v. Menillo*, 423 U.S. 9, 96 S.Ct. 170, 46 L.Ed.2d 152 (1975); *Roe*, 410 U.S. at 165, 93 S.Ct. at 732; *Spears v. Circuit Court*, 517 F.2d 360 (5th Cir. 1975).

abortion is performed in a hospital."[23] Two problems exist with this provision. First, this section limits access to abortions subsequent to the first trimester of pregnancy (post-first trimester) without regard to the preservation of maternal health. Second, this section represents an attempt by the State to regulate abortion prior to the time period when the State's interest in maternal health becomes compelling.

[6] A. *Restricting post-first trimester abortions to hospitals has no rational relationship to preservation of maternal health:* The Court notes that there are severe limitations on the availability of post-first trimester abortions in Louisiana. The Delta Clinics in New Orleans and Baton Rouge and the Orleans Women's Clinic "are the only health facilities in the State of Louisiana that either the Alan Guttmacher Institute[24] or the State Health Department have been able to identify as doing any second-trimester abortions."[25] The Court finds that there are no Louisiana hospitals performing abortions after the first trimester.[26] Counsel for defendants argued that hospitals will respond to the demand for abortions when clinics can no longer perform them.[27] However, hospitals have not responded to the present demand for post-first trimester abortions[28] by providing service in those areas outside New Orleans and Baton Rouge where there are presently no abortion facilities.[29] Thus, by requiring that post-first trimester abortions, that is abortions after the twelfth or thirteenth week of pregnancy, be performed in hospitals when hospitals are not presently nor prospectively available to perform such abortions is to effectively halt the performance of post-first trimester abortions in Louisiana. This result endangers maternal health by forcing a woman, more than

23. There is also a parallel section in La.Rev. Stat.Ann. § 37:1285(8.1) (West Supp.1979) under which the Louisiana State Board of Medical Examiners may revoke, suspend, or refuse to issue a doctor's license or place him on probation if he is found to be "[p]erforming or assisting in the performance of, or procuring, or abetting in the procuring of an abortion or termination of pregnancy after the first trimester: . . . . when the procedure is performed outside of a hospital licensed by the Department of Health and Human Resources, or its successor; . . ."

See Emma G. v. Edwards, 434 F.Supp. 1048 (E.D.La.1977) (provision requiring that all abortions, regardless of trimester, be done in a hospital was held unconstitutional).

24. The Alan Guttmacher Institute (hereinafter AGI) is an independent non-profit research corporation. Its figures on reproductive health care services are used as the official United States census statistics. Its figures are apparently more reliable than those compiled by the Center for Disease Control which is part of the Department of Health, Education and Welfare. Transcript of Barbara L. Lindheim (Lindheim Tr.) at 8-12.

25. Lindheim Tr. at 35. Although a military hospital in Louisiana performed two post-first trimester abortions in 1978, the hospital is only allowed to serve active military personnel and their dependents. Moreover, in the future no abortions will be permitted in military hospitals except to save the life of the mother. *Id.* at 30-31.

26. *See* n.25. Dr. Leggio's testimony that it was "common knowledge that Woman's Hospital in Baton Rouge does abortions" is unsupported. Transcript of Dr. Anthony B. Leggio, at 34. AGI figures show that the only two hospitals in Louisiana that do *first* trimester abortions "are both in New Orleans." Lindheim Tr. at 31. Moreover, the Consent for Treatment form at Woman's Hospital contains a disclaimer that if the woman is in an "abortive condition neither the attending physician or any person employed by or connected with the said WOMAN's HOSPITAL has knowingly performed any act which may have contributed to the induction of the abortion." P. Ex. 40.

27. This resembles the argument summarily rejected by the Sixth Circuit in *Wolfe v. Schroering*, 541 F.2d 523 (6th Cir. 1976), that "the ban of saline methods would hasten the development of the alternative prostaglandin method in Kentucky." *Wolfe*, 541 F.2d at 527.

28. Hospitals have also not responded to the need to provide facilities for first-trimester abortions. *See* n.26.

29. In fact, AGI figures indicate that *all* abortion facilities are located in either New Orleans or Baton Rouge. "[T]he State has not identified any providers of any abortion services at all anywhere else in the State of Louisiana except [New Orleans and Baton Rouge.]" Lindheim Tr. at 34. As a result, only 33% of the women who might need an abortion are able to obtain one, as opposed to an average of 71% in the rest of the country. Plaintiffs' Ex. 34A.

twelve weeks pregnant, to select from a range of alternatives more dangerous to maternal health than the performance of a post-first trimester abortion in a clinic, where such abortions are now safely performed.

The situation in Louisiana is analogous to the one described in *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976) (*Danforth*). In *Danforth*, the Supreme Court considered the constitutionality of a statute which prohibited the use of saline instillation as an abortion method after the twelfth week of pregnancy. At that time, "according to the testimony," *Danforth*, 428 U.S. at 76, 96 S.Ct. at 2844, about 70% of all post-first trimester abortions in the country were done by saline instillation. The only other method that was safer was prostaglandin instillation. Despite the fact that prostaglandin was *theoretically* available as an alternative method, the Supreme Court reversed because the lower court failed to consider certain factors:

> First, it did not recognize the prevalence, as the record conclusively demonstrates, of the use of saline amniocentesis as an accepted medical procedure in this country; the procedure as noted above, is employed in a substantial majority (. . . from 68% to 80%) of all post-first-trimester abortions. Second, it failed to recognize that at the time of trial, there were severe limitations on the availability of the prostaglandin technique, which, although promising, was used only on an experimental basis until less than two years before. See *Wolfe v. Schroering*, 388 F.Supp. at 637, where it was said that at that time (1974), there were 'no physicians in Kentucky competent in the technique of prostaglandin amnio infusion.' And appellees offered no evidence that prostaglandin abortions were available in Missouri. . . . Finally, the majority did not consider the anomaly inherent in § 9 when it proscribes the use of saline but does not prohibit techniques that are many times more likely to result in maternal death. *Danforth*, 428 U.S. at 77–78, 96 S.Ct. at 2845 (footnote omitted).

As in *Danforth*, the anomaly in the instant case is that the statute would act to proscribe the safest alternative presently available for post-first trimester abortions, that is performing post-first trimester abortions in a clinic. This would increase problems of maternal health care. Without clinics, a woman will have three options other than foregoing the abortion: self-induced abortion, procurement of an abortion or an abortifacient[30] from an unlicensed practitioner,[31] or travel to another state where post-first trimester abortions are available. The dangers inherent in the first two are clear.[32] The dangers inherent in forcing women out of state are more subtle. Women may lack access to out-of-state facilities.[33] Morbidity and mortality[34] rates will

30. Margaret S. II testified that she would have taken "pills" to produce a "spontaneous" abortion if she could not have obtained one at Delta. Transcript of Margaret S. II at 130.

31. There is also the possibility that doctors would continue to perform abortions, but would report them incorrectly as late first-trimester abortions. This has already occurred. Lindheim Tr. at 28–29.

32. The injuries suffered by women obtaining illegal abortions before *Roe* include perforated uteri, lacerated cervixes, sterility from untreated infections and death.

33. There is a significant relationship between a woman's distance from an abortion facility and the likelihood that she will obtain an abortion. This relationship impacts most heavily upon the poor, the young, and the members of minority groups. Lindheim Tr. at 47. Further, the out-of-state clinics may have only one or two already overburdened doctors available. Ironically, because "generally the availability of abortion services in the region is relatively low, and the involvement of hospitals in performing abortions is far lower in the region than in the nation as a whole," it is likely that the facilities for women who went to Florida, Georgia, Texas, Alabama, Mississippi, or Tennessee for post-first trimester abortions would in fact be clinics, rather than hospitals. *Id.* at 38.

34. Morbidity rates are general complication rates, usually non-fatal. Mortality rates are rates of fatal complications. Tietze Tr. at 67–68, 94–96.

rise because the abortion is delayed[35] and the follow-up is perforce negligible.[36] For many, the cost will be prohibitive.[37]

The emphasis in *Danforth* and *Wolfe v. Schroering*, 388 F.Supp. 631 (W.D.Ky.1974), *aff'd*, 541 F.2d 523, 526–27 (6th Cir. 1976), is on the lack of available alternative *methods* of post-first trimester abortions.[38] "The State, through [La.Rev.Stat.Ann. § 40:1299.35.3], would prohibit the use of a method [*i. e.* clinic post-first trimester abortions] which the record shows is the one most commonly used [in Louisiana] by physicians after the first trimester and which is safer, with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth." *Danforth*, 428 U.S. at 78, 96 S.Ct. at 2845. Moreover, "as a practical matter, it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." *Danforth*, 428 U.S. at 78–79, 96 S.Ct. at 2845. The requirement that post-first trimester abortions be performed in hospitals is not a "regulation [that] reasonably relates to the preservation and protection of maternal health." *Roe*, 410 U.S. at 163, 93 S.Ct. at 732. Rather, it is a requirement that "burden[s] an individual's right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision . . . ." *Carey v. Population Services International*, 431 U.S. 678, 688, 97 S.Ct. 2010, 2018, 52 L.Ed.2d 675 (1977).[39] This section also presents a second problem which the Court must address.

[7] B. *Because the dilation and evacuation (D & E) method of abortion up to the eighteenth week of pregnancy is safer than childbirth, the State's interest in regulating abortion prior to the eighteenth week of pregnancy is not "compelling"*: Under the rationale of *Roe*, "[t]he abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician" up to the point where maternal mortality rates in abortion approach those in childbirth. *Roe*, 410 U.S. at 164, 93 S.Ct. at 732. Before that point has been reached, "any interest of the State in protecting the woman from an inherently hazardous procedure, except when it would be equally dangerous for her to forego it,

35. Unintended pregnancies most often affect those with the least resources. "The fact is that barriers to availability of abortion, be they financial, or geographic, or procedural, tend to impact most strongly on young, poor, and minority women. At the same time, the women who are presented for second-trimester abortions tend also to be young and poor and minority more than the population in general, so you really are getting a double effect." Lindheim Tr. at 56–57. Black women have a mortality rate three times that of white women. Tietze Tr. at 97. Complications become more frequent and more serious with each week of delay. Tietze Tr. at 67–68, 170–81. *See* P. Ex. 27(G), (J).
Young teenagers who carry their pregnancies to term have much higher rates of toxemia (ten times), eclampsia and dystocia, and must undergo a Caesarean section much more often that older women. Crist Tr. at 137–39.

36. Crist Tr. at 37–38.

37. In other states, abortions after the first trimester of pregnancy performed in a hospital cost between $585 and $735 (hospital fee of $435 plus a surgeon's fee of $150 to $300). Lindheim Tr. at 51–53. First-trimester clinic abortions average $175. *Id.* at 54. If Louisiana women were added to the out-of-state demand for post-first trimester abortions, "prices would probably go up because you have more demand being placed on a limited supply." *Id.* at 54–55. *See* Complaint, ¶ III.(A)(5).

38. "[Prostaglandin] is not readily available in this geographical territory. . . . With prostaglandin unavailable, and saline prohibited, the woman wishing abortion after the first trimester is practically rendered destitute, her only recourse, hysterotomy, being by far the most dangerous of the three methods." *Wolfe*, 388 F.Supp. at 637. Banning the saline method was " 'almost tantamount' to a prohibition of post-first trimester abortions." *Wolfe*, 541 F.2d at 527 (Stephens, J. concurring in part and dissenting in part, *quoting Danforth*, 428 U.S. at 102, 96 S.Ct. at 2856).

39. An out-of-state abortion cannot be safer than an in-state dilation and evacuation method (D & E) abortion. Even if the out-of-state facility used the D & E procedure, the delay caused by looking for the facility and travelling to it would increase the morbidity and mortality rates. Every day's delay is statistically significant. *See* P. Ex. 27(G), (J); Tietze Tr. at 67–69, 71–74, 95.

has largely disappeared."[40] *Roe*, 410 U.S. at 149, 93 S.Ct. at 725. *Roe* held that the State's compelling interest in maternal health "in light of present medical knowledge" emerged at the end of the first trimester. *Roe*, 410 U.S. at 163, 93 S.Ct. at 731. "This is so because of the now-established medical fact, referred to above, that until the end of the first trimester mortality in abortion may be less than mortality in childbirth." *Roe*, 410 U.S. at 163, 93 S.Ct. at 732.[41]

Since the *Roe* decision, major advances have occurred in medical knowledge.[42] The post-first trimester abortion technique, dilation and evacuation (D & E), was relatively unknown at the time of the *Roe* decision. Presently, D & E has become the most common procedure employed to terminate pregnancies where the gestation period exceeds twelve weeks. D & E is an accepted method of abortion that is far safer than any other method currently used. In Louisiana, nearly all doctors use the D & E method when performing post-first trimester abortions; and, both Delta and Orleans Women's Clinic use the D & E method when performing post-first trimester abortions. Based upon the evidence presented at trial, the Court finds that the D & E method of abortion up to the eighteenth week of pregnancy is safer than childbirth.[43] If there is no *compelling* state interest until abortion threatens maternal health in the same degree as does childbirth, then the State cannot impose regulations at a time—after the twelfth week and before the eighteenth week of pregnancy—

40. "[N]o published studies presently available directly compare the safety of hospital and non-hospital second-trimester abortions . . . [However, an HEW study (P. Ex. 17, at 8)] revealed no major differences between the risks of death in the two types of institutions, and emphasized that 'operator skill was probably more important than operative setting as a risk factor.' . . . . If non-hospital facilities, therefore, meet adequate minimum standards for dealing with the complications which may occur with second-trimester abortion, there is no longer any reason to believe that the hospital setting is safer. *Indeed if, as this study concludes, operator skill is the critical factor in predicting risk of morbidity and mortality associated with abortion, non-hospital facilities may well be much safer because of the extensive abortion experience of physicians in such clinics.*" The American Public Health Association (APHA) Brief at 17–18 (emphasis added). *See also* Tietze Tr. at 82 ("The high [death] rates in the first two years [after *Roe*] are doubtless a reflection of the inexperience at that time, and what you can also demonstrate is, as I have indicated, from data in Britain [a falling death rate] is just as with us, doctors learning.") and *Id.* 137–38.

It would not promote maternal welfare to compel women to obtain post-first trimester abortions in hospitals, if they were available, where the doctors are almost totally inexperienced, rather than to allow women to benefit from the clinic doctors' expertise. Crist Tr. at 30–32.

41. In reaching this conclusion the Supreme Court referred in a footnote, 410 U.S. at 149 n.44, 93 S.Ct. at 725 n.44, to several studies, including three by Dr. Tietze.

42. *See* APHA Brief at 3, 14.

43. Tietze Tr. at 102–103. Grimes, et al., *Methods of Mid-Trimester Abortion: Which is Safest?*, International Journal of Gynecology & Obstetrics 15:184, 186 (1977) ("significantly safer than saline") (HEW study); Cates, et al., *The Effect of Delay and Method Ch[illegible]e on the Risk of Abortion Morbidity*, 9 Family Planning Perspectives 266, 268 (1977) ("D & E was more than 160 per cent safer than saline instillation, which in turn was 60 per cent safer than [prostaglandin] instillation.") (study done by the Dept. of Health, Education & Welfare's Center for Disease Control); Plaintiffs' Exhibit 27(K) at T24-6 (slide presented by Dr. Tietze) (6.6 deaths per hundred thousand abortions as compared to 13.7 per hundred thousand for normal childbirth.); APHA Brief at 14–17. Note, moreover that the Louisiana maternal mortality rate has ranged as high as 21.5 per hundred thousand livebirths. Defendants' Answers to Plaintiffs' Interrogatories, Attachment VI, at 7 (1976 figure). Use of the D & E method was not considered in *Wynn*, 449 F.Supp. at 1318.

A statute that permitted post-first trimester D & E abortions to be performed in clinics but required that post-first trimester abortions performed by any other method be done in hospitals was recently upheld as rational, because of the safety of the D & E method. *Livingston v. New Jersey Bd. of Medical Examiners*, 168 N.J. Super. 259, 402 A.2d 967 (1979).

Dr. Wood, who is associated with Delta, performed over 2,400 abortions in the last four years using the D & E method. About 1700 of these were done after the first trimester. Tietze Tr. at 76. His reported morbidity rate using the D & E method is two-thirds better than the national rate. *Id.*

when the abortion method used, D & E, is far safer than childbirth.[44] Thus, the State's interest in protecting maternal health does not become compelling until the eighteenth week of pregnancy.

[8] Because La.Rev.Stat.Ann. § 40:1299.35.3 (West Supp.1979) requires abortions after the first trimester to be performed in a hospital, limiting access to abortion without regard to preservation of maternal health, and because it attempts to regulate abortions prior to the time when the State's interest in maternal health becomes compelling, the Court holds that the instant section is unconstitutional. *Accord, Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft*, 483 F.Supp. 679 at 685–687 (W.D.Mo.1980).

ABORTION AFTER VIABILITY: LA. REV.STAT.ANN. § 40:1299.35.4 (WEST SUPP.1979)

A. *Roe* provides that the State, because of its legitimate interest in potential life, may regulate and even forbid abortions after a fetus becomes viable, "except when it is necessary to preserve the life or health of the mother." *Roe*, 410 U.S. at 164, 93 S.Ct. at 732. The first sentence of La.Rev.Stat. Ann. § 40:1299.35.4(A) (West Supp.1979),[45] while appearing to follow the guidelines set forth in *Roe*, uses the phrase "to prevent *permanent impairment* to her health." (Emphasis added.) This is not the same standard articulated in *Roe, preservation of maternal health.* A doctor could determine that an abortion was necessary for the preservation of the immediate health of the mother (an emergency), or for the preservation of her health in the near future (a woman presently unable to face the stress of childbearing), or for the preservation of her health in the distant future (a woman for whom another pregnancy would mean an elevated risk of having a serious, but not permanent, illness). In other words, the concern may be for the mother's immediate or long-term health. This section, on the other hand, only permits an abortion after viability where it will prevent permanent impairment to a woman's health. Even if doctors could determine in advance which births would create risks of "permanent" impairment, it is impermissible to force them to do so. Preserving maternal health means more than preventing permanent incapacity. A rape or incest victim may not be able to prove that her mental health will be *permanently* impaired if she is forced to bear her attacker's child, but she might be able to show that it is necessary to preserve her immediate mental health. The Act eliminates consideration of any disability that is not permanent, even if the impairment lingers for months or years before it ultimately disappears. The Court finds that the requirement of *permanent* impairment impermissibly constricts the meaning of *Roe*.

[9] This section also requires that the attending physician obtain the certification of one or perhaps two other doctors[46] to confirm his judgment as to both the necessity of performing the abortion and the consequences of not doing so. Such "confirmation" proceedings will not withstand constitutional challenge:

44. The defendants introduced no evidence to show either that D & E was not the method of choice of the Louisiana doctors who do post-first trimester abortions or that they were not the "skilled" operators referred to in Dr. Tietze's testimony. Tietze Tr. at 103.

45. La.Rev.Stat.Ann. § 40:1299.35.4(A) states:

> No physician shall perform or induce an abortion upon a pregnant woman after such time as her unborn child has become viable, unless such abortion is necessary to prevent the death of the pregnant woman or to prevent permanent impairment to her health. Before a physician may perform or induce an abortion upon a pregnant woman after such time as her unborn child has become viable, two physicians after examining the patient shall first certify in writing that the abortion is necessary to prevent the death of a pregnant woman or to prevent permanent impairment to her health and shall further certify in writing the medical indications for such abortion and the probable health consequences if the abortion is not performed or induced.

46. It is unclear whether the original physician may be one of the two certifying physicians. The State argues that only one other physician is necessary.

If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice.

Doe v. Bolton, 410 U.S. 179, 199, 93 S.Ct. 739, 751, 35 L.Ed.2d 201 (1973).

The Court therefore holds that La.Rev.Stat. Ann. § 40:1299.35.4(A) is an unconstitutional infringement upon a physician's right to practice.

B. La.Rev.Stat.Ann. § 40:1299.35.4(B)[47] establishes a presumption of viability for fetuses that are more than twenty-four weeks old. *Roe* and its progeny[48] have made it clear that neither legislatures nor courts may establish such presumptions. Determination of viability is a decision which *must* be left to the attending physician.

[V]iability [is] a matter of medical judgment, skill, and technical ability . . . [I]t is not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period. The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician.

Danforth, 428 U.S. at 64, 96 S.Ct. at 2539 (discussing, in part, *Roe*'s analysis).

This determination was recently reaffirmed in *Colautti v. Franklin*, 439 U.S. 379, 99 S.Ct. 675, 58 L.Ed.2d 596 (1979) (*Colautti*):

Viability is reached when, in the judgment of the attending physician on the particular facts of the case before him, there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support. Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability—be it weeks of gestation or fetal weight or any other single factor—as the determinant of when the State has a compelling interest in the life or health of the fetus. Viability is the critical point. And we have recognized no attempt to stretch the point of viability one way or the other.

Colautti, 99 S.Ct. at 682.

Defendants argue that the statute imposes only a *presumption* of viability which the physician can rebut on the basis of his own examination. However, this apparent flexibility cannot save the section. In a significant number of pregnancies doctors cannot accurately[49] determine how old the fetus is

47. La.Rev.Stat.Ann. § 40:1299.35.4(B) states:
An unborn child shall be presumed to be viable if more than twenty-four weeks have elapsed from the probable beginning of the last menstrual period of the pregnant woman, based upon either information provided by her or through examination by her attending physician. If it is the judgment of the attending physician that the particular unborn child is not viable where the presumption of viability exists, then before such physician may perform or induce an abortion upon the pregnant woman he shall first certify in writing that the particular unborn child is not viable and shall further certify the precise medical findings upon which he bases that judgment.
Since § 40:1299.35.6(B)(4) (see *infra*) assumes that conception occurs two weeks after the last menstrual period (LMP), the Act is based on a premise that both ovulation and conception occur exactly fourteen days after the onset of the last menstrual period. However, "[e]stimates of gestational age based on LMP cannot be determined in 15-30 per cent of pregnancies." P. Ex. 19, at 12-3 (The report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, entitled *Research on the Fetus*, published by the Dept. of Health, Education & Welfare).

48. *See Hodgson v. Lawson*, 542 F.2d 1350, 1355 (8th Cir. 1976); *Floyd v. Anders*, 440 F.Supp. 535, 539 (D.S.C.1977); *Wolfe v. Schroering*, 388 F.Supp. 631, 635 (W.D.Ky.1974), *aff'd* 541 F.2d 523 (6th Cir. 1976).

49. *See* n.47 *supra*. Many women have irregular periods and some continue to have "spotting" after they become pregnant so that a real LMP cannot be determined. Testimony of Dr. Wilke (Benshoof Aff. ¶ 39) and Dr. Jackson

and cannot, therefore, determine whether the presumption is applicable. Even the most modern technique, ultrasonic cephalometry,[50] has an error rate of plus or minus two weeks.[51] In order to avoid aborting a twenty-six-week-old fetus, doctors would have to cease doing abortions after the twenty-third week.[52]

[10] More fundamentally, it would be impossible to rebut a presumption of viability with absolute certainty. Viability cannot be determined with *precision* until after birth. The question of whether a particular infant will survive cannot be answered before the infant is born. Before then, it is a matter of statistical probability, involving estimates of fetal age, health, weight, maternal health, and the availability of neonatal care.[53] Since the Act does not make the doctor's good faith determination of non-viability conclusive,[54] the State could bring a criminal action questioning the doctor's determination. In such a criminal action, "precise medical findings" that a fetus had less than 1/250,000 chance of survival[55] might be insufficient for certain juries. *See Colautti*, 99 S.Ct. at 686. In order to protect himself, a doctor could not rely on his own findings and belief that, under the circumstances, a particular fetus was or was not viable, but would be forced to abide by the latest statistics from the most modern neo-natal care center and hope that the local prosecutor had the same figures. This is a statute that is ripe for "arbitrary and erratic arrests and convictions." *Papachristou v. City of Jacksonville*, 405 U.S. 156, 162, 92 S.Ct. 839, 843, 31 L.Ed.2d 110 (1972). It is also a statute that, by setting up an essentially irrebuttable presumption of viability, effectively takes the determination of viability out of the hands of the physician. The Court holds that La.Rev.Stat. Ann. § 40:1299.35.4(B) is an unconstitutional infringement on a physician's right to practice medicine.

C. La.Rev.Stat.Ann. § 40:1299.35.4(C)[56] requires that once the presumption of viability exists the doctors must use the abortion method most likely to preserve the

(Levin Aff. ¶ 26). The problem is compounded for women who do not keep accurate records of their periods so that a pattern can be established or who are dealing with doctors who, because they are not regular family physicians, are not familiar with the patient's menstrual cycle. Moreover, a doctor cannot rely on estimates of fetal weight (obtained by manual abdominal palpation) to determine gestational age. "The error of the experienced obstetrician in determining fetal weight in this matter increases with decreasing weight from the end of the first trimester through the beginning of the second trimester and may be greater than 100 per cent. Thus, the physician's estimate of the weight of a 600 gram fetus *in utero* may be consistent with delivery of a 1000-2000 gram premature infant." P. Ex. 19, at 12-8. Fetal age may be *estimated* by several methods, including chemical analysis, *id.*, but even "combined use of several of these methods to estimate gestational age has not demonstrably decreased this [plus or minus two weeks rate of] error." *Id.* The most accurate measure of gestational age *at birth* also has an error rate of plus or minus two weeks. *Id.* at 12-16.

50. This technique compares the fetus' linear head dimensions with those obtained from fetuses of women with reliable menstrual periods. P. Ex. 19, at 12-8.

51. *Id.*

52. Given the criminal penalties for making a wrong guess, more cautious or more inexperienced doctors might retreat even further. Crist Tr. at 50. Apparently, some forms of genetic testing cannot be done until after eighteen to twenty weeks gestation. *Colautti v. Franklin*, 439 U.S. 379, 99 S.Ct. 675, 682 n.8, 58 L.Ed.2d 596 (1979) (*Colautti*).

53. P. Ex. 19, at 12-6, 50 (Figure 4).

54. As argued by plaintiff's counsel in *Colautti*, the State could, for example, "[have made] the physician's good-faith determination of viability conclusive." *Colautti*, 99 S.Ct. at 682.

55. Based on Canadian data, a probability of 1/276,531 is actually a 3.6 chance per million live births, for fetuses weighing 601-650 grams. Similar weight data based on total deliveries at one major premature referral center are not available for the United States. *But see* P. Ex. 19, at 12-5, 12-91 to 12-103 (Tables 17-22, 25).

56. La.Rev.Stat.Ann. § 40:1299.35.4(C) states: "Any physician who shall perform or induce an abortion upon a pregnant woman where the presumption of viability exists shall utilize the available method or technique of abortion most likely to preserve the life and health of the unborn child."

fetus. Even if the presumption of viability were valid, this section does not meet the standard set forth in *Roe*, which allows the State to forbid every abortion after viability "except when it is necessary to preserve the life or health of the mother." *Roe*, 410 U.S. at 164, 93 S.Ct. at 732. It is undisputed that the method most likely to preserve the life of the fetus is a hysterotomy,[57] a form of major surgery in which the contents of the uterus are removed through an abdominal incision.[58] However, this is also the method involving the highest risk to the mother's health.[59] As a result of this section,[60] a doctor who has determined that an abortion near the time of viability is necessary to preserve the life or health of the mother faces a dilemma: although the purpose of the operation is to preserve a woman's health, this section forces the doctor to perform a hysterotomy, the operative method most dangerous to his patient. Presumably the doctor owes an ethical duty to the woman who is his patient, a duty which mandates use of the *least* dangerous method of abortion. This section, by forcing him to disregard his duty to the woman, paralyzes his ability to act in those situations "when it is necessary to preserve the life or health of the mother." *Roe*, 410 U.S. at 164, 93 S.Ct. at 732.[61] If he performs a dilation and evacuation, he is liable under the Act for failure to consider the fetus. If he performs a hysterotomy, he would be open to a malpractice action for failure to consider the woman.

[11] The Supreme Court has recently passed upon the Pennsylvania Abortion Control Act, Pa.Stat.Ann., Tit. 35, § 6605(a) (Purdon 1977), which "subjects a physician who performs an abortion to potential criminal liability if he fails to utilize a statutorily prescribed technique when the fetus 'is viable' or when there is 'sufficient reason to believe that the fetus may be viable.'" *Colautti*, 99 S.Ct. at 678. The Pennsylvania statute directs the physician to employ an abortion technique best suited to fetal survival "'so long as a different technique would not be *necessary* in order to preserve the life or health of the mother.'" *Colautti*, 99 S.Ct. at 688 (citing Pa.Stat.Ann., Tit. 35, § 6605(a)) (original emphasis). This statute is similar to La.Rev.Stat.Ann. § 40:1299.35.4(C), with one noteworthy difference: the Pennsylvania statute recognizes the importance of the preservation of the mother's health and welfare when the health interests of the fetus and mother conflict. The Louisiana statute, on the oth-

57. Tietze Tr. at 79; Crist Tr. at 48. *See also Colautti*, 99 S.Ct. at 687. Injections of prostaglandin and saline solution expose the fetus to toxic chemicals and traumatic expulsion from the womb. Both D & E and D & C abortions involve cutting and crushing of the fetus.

58. A post-operative hospital stay of five to seven days is required. Defense witness Dr. James Moorman stated that "any time you put a scar through the uterus you make a woman a reproductive cripple . . . ." Moorman Tr. at 134.

59. "Hysterotomies [are] most likely to protect the life of the fetus and [have] the highest complication rate for the woman; prostaglandin produces quite often a live, although not surviving, fetus, which has the next lower complication rate; saline almost never produces a live fetus, and that complication rate is still smaller, [in terms of a] major complication rate; then D & E never produces a live fetus, and the complication rate is lowest, so the order is exactly reversed." Tietze Tr. at 79-80. *See also* P. Ex. 27(H) (morbidity rates); P. Ex. 14, Table 23 (mortality rates).

60. There is a parallel section in La.Rev.Stat. Ann. § 37:1285(8) (West Supp.1979):

> The [Louisiana State Board of Medical Examiners] may refuse to issue, or may suspend or revoke any license or permit, or impose probationary or other restrictions on any license or permit . . for . . . :
> . . . (8) Performing, or assisting in the performance of, or procuring or abetting in procuring an abortion or termination of pregnancy during the third trimester or after viability of the fetus, unless the physician determines that such abortion or termination of pregnancy is necessary, in his best medical judgment, in order to save the life or health of the pregnant woman and/or of the fetus (unborn child) . . . .

61. The instant section attempts to extend the physician-patient relationship to the fetus *as a separate individual. See* Note, *Medical Responsibility of Fetal Survival Under Roe and Doe*, 10 Harv.Civ.Rts.—Civ.Lib.L.Rev. 444 (1975).

er hand, orders the physician to employ an abortion technique most likely to preserve the health of the fetus without regard to the preservation of maternal health. Thus, the Pennsylvania statute provides greater protection for the preservation of maternal welfare than does the Louisiana statute. The Supreme Court, however, struck down the Pennsylvania statute because:

> it is uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a "trade-off" between the woman's health and additional percentage points of fetal survival. Serious ethical and constitutional difficulties, that we do not address, lurk behind this ambiguity. We hold only that where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions.
>
> *Colautti*, 99 S.Ct. at 688.

La.Rev.Stat.Ann. § 40:1299.35.4(C) places the physician in a graver dilemma than the Pennsylvania statute because it is silent with respect to the protection of the mother's health. This Court concludes that La. Rev.Stat.Ann. § 40:1299.35.4(C) is void for vagueness.

D. La.Rev.Stat.Ann. § 40:1299.35.4(D)[62] requires that a second physician be in attendance when a fetus is aborted after viability.[63] The pregnant woman's physician, while he is inducing the abortion, and the second physician, after the abortion, "shall take all reasonable steps . . . to preserve the life and health of the unborn child."

Once viability exists, "the State's important and legitimate interest in potential life" becomes compelling. *Roe*, 410 U.S. at 163–64, 93 S.Ct. at 732. In order to protect that interest, the State may regulate post-viability abortions heavily or it may forbid them outright, except when it is necessary to preserve the life or health of the mother. *Roe*, 410 U.S. at 163, 93 S.Ct. at 731. Thus, this Court rejects the argument that once the State decides to allow post-viability abortions, it must allow them to be done under the least restrictive conditions. The mere requirement that a second physician be present does not invade the first physician's right to practice medicine since there is no requirement that the second physician approve of any action that the first physician takes. It is apparent that, no matter which abortion method a doctor uses, the second physician will seldom serve any useful function.[64] However, the State can choose to be prepared for those rare instances when there is a live birth. *See Floyd v. Anders*, 440 F.Supp. 535 (D.S.C. 1977) (fetus aborted in 25th week survived twenty days after prostaglandin injection).

The argument that the requirement will add severely to the cost[65] of these abortions

62. La.Rev.Stat.Ann. § 40:1299.35.4(D) states: An abortion of a viable child shall be performed or induced only when there is in attendance a physician other than the physician performing or inducing the abortion who shall take control of and provide immediate medical care for a child born as a result of the abortion. During the performance or inducement of the abortion, the physician performing or inducing it, and subsequent to the abortion, the physician required by this Subsection to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the unborn child.

63. Because of the discussion above, the Court considers this subsection as using "viable" only as it is defined in § 40:1299.35.1(3), and not as including those situations where the "presumption" of viability would allegedly exist.

64. *See* n.57 *supra*.

65. The Court notes that Margaret S. II and many members of Class A are poor women. However, the "[Supreme] Court has never held that financial need alone identifies a suspect class for purposes of equal protection analysis." *Maher v. Roe*, 432 U.S. 464, 471, 97 S.Ct. 2376, 2381, 53 L.Ed.2d 484 (1977). *See Ross v. Moffitt*, 417 U.S. 600, 615, 94 S.Ct. 2437, 2446, 41 L.Ed.2d 341 (1974); *San Antonio Independent School District v. Rodriguez*, 411 U.S. 1, 29, 93 S.Ct. 1278, 1294, 36 L.Ed.2d 16 (1973). However, "[t]he Supreme Court's declining commitment to economic justice . . . must not be permitted to obscure the continuing relevance of economic inequality to issues

is not persuasive in favor of striking the section. In *Maher v. Roe*, 432 U.S. 464, 97 S.Ct. 2376, 53 L.Ed.2d 484 (1977), the Supreme Court held that states could refuse to provide any public funding for elective abortions despite the heavy impact this would have on a poor woman's choice whether or not to have an abortion.

> The Connecticut regulation places no obstacles—absolute or otherwise—in the pregnant woman's path to an abortion. An indigent woman who desires an abortion . . . continues as before to be dependent on private sources for the service she desires. The State may have made childbirth a more attractive alternative, thereby influencing the woman's decision, but it has imposed no restriction on access to abortions that was not already there. The indigency that may make it difficult—and in some cases, perhaps, impossible—for some women to have abortions is neither created or in any way affected by the Connecticut regulation.
>
> *Maher v. Roe*, 432 U.S. at 474, 97 S.Ct. at 2383.[66]

A similar "value judgment favoring childbirth over abortion" which the Court found permissible in *Maher v. Roe*, 432 U.S. at 474, 97 S.Ct. at 2382, is at work in this section: the Louisiana statute is designed to enhance the probability of survival, however minute, for fetuses aborted in post-viability abortions. The mere physical presence, therefore, of a second physician is not impermissible.

[12] Although the requirement that a second physician be present is permissible, La.Rev.Stat.Ann. § 40:1299.35.4(D) is invalid because it suffers from the same infirmities as La.Rev.Stat.Ann. § 40:1299.35.4(C). La.Rev.Stat.Ann. § 40:1299.35.4(D) requires that "[d]uring the performance or inducement of the abortion, the physician . . . shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the unborn child." This places the physician in the same dilemma of making "a 'trade-off' between the woman's health and additional points of fetal survival." *Colautti*, 99 S.Ct. at 688.

Furthermore, this requirement raises other serious questions. For example, if a doctor decided to do a hysterotomy, to whom is his duty owed "in keeping with good medical practice"? If it is to the mother, can the second doctor intervene if he decides that the first doctor is *not* taking all the reasonable steps he could to preserve the fetus?[67] An operating room is not a practical place to resolve such ethical disputes. The danger that the mother's health will be jeopardized is clear. The physical

of personal liberty when restrictive laws take their greatest toll upon the poor." Tribe, at 931 n.68. *See Maher v. Roe*, 432 U.S. at 482-83, 97 S.Ct. at 2386-87 (Brennan, J., dissenting); *Beal v. Doe*, 432 U.S. 454, 455-56, 97 S.Ct. 2394, 2395, 53 L.Ed.2d 464 (1977) (Marshall, J. dissenting). *Fox Valley Reproductive Health Care Center, Inc. v. Arft*, 446 F.Supp. 1072, 1073-74 (E.D.Wis.1978), granted a preliminary injunction against massive regulation at least in part because it would have doubled or tripled the cost of first-trimester abortions. *But see McRae v. Department of Health, Education and Welfare*, No. 76C 1804 (E.D.N.Y. Jan. 15, 1980) probable jurisdiction noted by United States Supreme Court February 19, 1980.

66. *But cf. Zablocki v. Redhail*, 434 U.S. 374, 98 S.Ct. 673, 54 L.Ed.2d 618 (1978) (Discussing the economic effect of a statute that directly infringed on indigents' right to marry (a fundamental right)).

67. Similarly, would the second physician have the right to prevent injection of more saline solution or prostaglandin if the first physician wanted to speed up the proceedings to shorten the mother's labor time in order to save her mental anguish or physical pain or to save himself waiting time? Who would referee such disputes? *See* questions raised in *Hodgson v. Flakne*, 463 F.Supp. 67 (D.Minn.1978); *Wynn v. Scott*, 449 F.Supp. 1302, 1319 (N.D.Ill.1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979) ("[The section] does not clarify whether the attending physician may perform an abortion after viability if the consulting physicians do not agree that the procedure is medically necessary to preserve the woman's life or health. Undoubtedly the attending physician would prefer to err on the side of safety and forego the abortion, even if his or her professional belief that the abortion was necessary were sincere and well founded").

relationship between the woman and the fetus is too close to allow two physicians to pursue adverse treatment strategies for the mother and fetus. Thus, this Court holds that "where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions." *Colautti*, 99 S.Ct. at 688.

NOTICE AND CONSENT: LA.REV. STAT.ANN. § 40:1299.35.5 (WEST SUPP.1979)

La.Rev.Stat.Ann. § 40:1299.35.5 (West Supp.1979) consists of two paragraphs, § 40:1299.35.5(A)[68] and § 40:1299.35.5(B).[69] These two paragraphs impose certain restrictions on the ability of a minor pregnant woman to obtain an abortion, thus restricting the minor's right of privacy. "Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights." *Danforth*, 428 U.S. at 74, 96 S.Ct. at 2843. However, this Court recognizes that "the State has somewhat broader authority to regulate the activities of children than of adults." *Danforth*, 428 U.S. at 74, 96 S.Ct. at 2843.

The Supreme Court has "recognized three reasons justifying the conclusion that the constitutional rights of children cannot be equated with those of adults: the peculiar vulnerability of children; their inability to make critical decisions in an informed mature manner; and the importance of the parental role in child-rearing." *Bellotti v. Baird*, 443 U.S. 622, 99 S.Ct. 3035, 3043, 61 L.Ed.2d 797 (1979) (*Bellotti*). "In [La.Rev. Stat.Ann. § 40:1299.35.5 Louisiana] has attempted to reconcile the constitutional right of a woman, in consultation with her physician, to choose to terminate her pregnancy as established by *Roe v. Wade* [410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973)] and *Doe v. Bolton* [410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201 (1973)], with the special interest of the State in encouraging an unmarried pregnant minor to seek the advice [and/or consent] of her parents in making the important decision whether or not to bear a child." *Bellotti*, 99 S.Ct. at 3046. This Court is:

> concerned here with a constitutional right to seek an abortion. The abortion decision differs in important ways from other decisions that may be made during minority. The need to preserve the constitutional right and the unique nature of the abortion decision, especially when made by a minor, require a State to act with particular sensitivity when it legislates to foster parental involvement in this matter.

Bellotti, 99 S.Ct. at 3047.

With these principles in mind, the Court will analyze whether La.Rev.Stat.Ann. § 40:1299.35.5 meets constitutional standards. For convenience, the Court will first address the problems raised in paragraph B of La.Rev.Stat.Ann. § 40:1299.35.5.

68. La.Rev.Stat.Ann. § 40:1299.35.5(A) states:

> No physician shall perform or induce an abortion upon an unmarried pregnant woman under the age of eighteen years without first having given at least twenty-four hours actual notice to one of the parents or the legal guardian of the minor pregnant woman as to the intention to perform such abortion, or if such parent or guardian cannot be reached after a reasonable effort to find him or her, without first having given at least seventy-two hours constructive notice to one of the parents or the legal guardian of the minor pregnant woman by certified mail to the last known address of one of the parents or guardian, computed from the time of mailing, unless the abortion is ordered by a court having jurisdiction over such minor pregnant woman.

69. La.Rev.Stat.Ann. § 40:1299.35.5(B) states:

> No physician shall perform or induce an abortion upon a minor pregnant woman under the age of fifteen years without first having obtained the informed written consent of the minor pregnant woman in accordance with 40:1299.35.6, and
>
> 1. First having obtained the informed written consent of one of her parents or her legal guardian in accordance with R.S. 41:1299.35.6, or
>
> 2. The minor pregnant woman first having obtained an order from a court having jurisdiction over her that the abortion be performed or induced.

CONSENT: LA.REV.STAT.ANN. § 40:1299.35.5(B) (WEST SUPP.1979)

[13] La.Rev.Stat.Ann. § 40:1299.35.5(B) requires that any minor under the age of fifteen who desires an abortion must obtain either the written consent of her parent or guardian, or obtain an order from a court having jurisdiction over her permitting the abortion to be performed.[70] The constitutionality of this paragraph is not a case of first impression because the Supreme Court has enunciated certain guidelines in *Bellotti*. There, the Supreme Court concluded: "if the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained." *Bellotti*, 99 S.Ct. at 3048. Although La.Rev.Stat.Ann. § 40:1299.35.5(B) provides an alternative procedure, the Court must decide whether this procedure complies with strictures enunciated in *Bellotti*. This section says nothing more than the pregnant minor may receive an order from a "court having jurisdiction over her that the abortion be performed or induced." This is not enough:

> A pregnant minor is entitled in such a proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests. The proceeding in which this showing is made must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained.
>
> *Bellotti*, 99 S.Ct. at 3048–49 (footnotes omitted).[71]

Applying the above quoted language from *Bellotti* to the instant section, the Court notes the following infirmities. La.Rev.Stat.Ann. § 40:1299.35.5(B) sets forth no standards or guidelines for the minor seeking judicial approval for abortion. For example, no provision is made for expedited hearing and for expedited appeal, the necessity for which is obvious in an abortion situation. Also the instant section does not insure the minor's anonymity during the judicial proceeding. The Court holds that La.Rev.Stat.Ann. § 40:1299.35.5(B) fails to provide a procedure which satisfies the standards enunciated in *Bellotti* and it is, therefore, unconstitutional.

NOTICE: LA.REV.STAT.ANN. § 40:1299.35.5(A) (WEST SUPP.1979)

La.Rev.Stat.Ann. § 40:1299.35.5(A)[72] states that a physician cannot perform an abortion until he gives twenty-four hours actual notice or seventy-two hours constructive notice to a parent or legal guardian of all unmarried women under the age of eighteen who decide to obtain an abortion. The notice requirement is unnecessary if a court orders the abortion.[73] The Court must decide whether this requirement infringes upon the ability of a minor to obtain an abortion, thus restricting the minor's constitutional right of privacy.

70. La.Rev.Stat.Ann. § 40:1299.35.5(B) also requires that the doctor obtain the "informed consent," as detailed in La.Rev.Stat.Ann. § 40:1299.35.6, of the minor and the parent. The Court will assume for purposes of this discussion that only those parts of La.Rev.Stat.Ann. § 40:1299.35.6 which the Court has upheld are included. *See* text accompanying nn. 76–82.

71. Even though a majority of the Justices in *Bellotti v. Baird*, 443 U.S. 622, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979) (*Bellotti*) did not join the Court's opinion written by Justice Powell, this Court holds that the standard enunciated by the Supreme Court can be relied upon as a guide which sets forth the minimum procedural guarantees.

72. See n.68, *supra*.

73. See n.68, *supra*. It is not clear whether this section was intended to set up a procedure which permits an unmarried woman under the age of eighteen to request a court order waiving the notice requirement or whether it was intended merely to relieve the physician of the additional burden of sending out the notice in a case in which the court has ordered that the abortion be performed. Merely clarifying this ambiguity would not relieve this section of serious constitutional difficulties.

The Court notes that while this section applies to all unmarried women under the age of eighteen, its effect upon the age group between fifteen and seventeen years must be considered separately from its effect upon the age group less than fifteen years old. A pregnant woman under the age of fifteen has an option either to obtain a court ordered abortion without notifying her parents or to obtain parental consent which will operate to notify her parents.

The State chose to exclude the age group between fifteen and seventeen from any requirement of parental consent before obtaining an abortion. See La.Rev.Stat.Ann. § 40:1299.35.5(B) (West Supp.1979). Apparently, the State determined that a minor woman between the ages of fifteen and seventeen is mature enough to make the decision whether to obtain an abortion without the necessity of either parental consent or a court order. Thus in Louisiana the following paradoxical situation exists: A seventeen year old woman, deemed by the State to be mature enough to obtain an abortion without parental consent, must nonetheless notify her parents that she is seeking an abortion or obtain a court ordered abortion.

Ostensibly, the notice requirement furthers the State's interest in insuring that parents are given the opportunity to participate in an important and potentially traumatic decision in the life of their minor daughter, thus promoting family dialogue and harmony. However, any state interest in encouraging consultation between the daughter who is seeking an abortion and her parents is not necessarily achieved by the notice requirement because merely giving notice to the parents does not assure that there will be any meaningful dialogue. In many cases the notice requirement will cause family disharmony because it will inform parents who may oppose their daughter obtaining an abortion, yet, those parents will be legally powerless to prevent their daughter from obtaining an abortion.

The most significant difficulty with La. Rev.Stat.Ann. § 40:1299.35.5(A) is that it does not consider the minor's constitutional right of privacy. The Supreme Court has indicated that the constitutionally protected "zone of privacy" involves at least two different kinds of interests. "One is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions." *Whalen v. Roe*, 429 U.S. 589, 599–600, 97 S.Ct. 869, 876, 51 L.Ed.2d 64 (1977) (footnotes omitted). La. Rev.Stat.Ann. § 40:1299.35.5(A) substantially affects a minor's right to avoid the disclosure of personal matters. One of the most personal matters that can be disclosed is the fact that a woman is seeking an abortion.[74] *Roe* commands that, during the first trimester, "the abortion decision . . . must be left to the medical judgment of the pregnant woman's attending physician." *Roe*, 410 U.S. at 164, 93 S.Ct. at 732. The physician, "in consultation with his patient" and no one else, must determine whether or not to go ahead with the abortion. *Roe*, 410 U.S. at 163, 93 S.Ct. at 731. Privacy can not exist when third parties are privy to the discussion. Furthermore, this section may also have a chilling affect on the minor's right to independently make certain kinds of important decisions which are the basis of a woman's constitutional right to obtain an abortion. *Roe*, 410 U.S. at 152–62, 93 S.Ct. at 726–31. Thus, both kinds of privacy interests are at issue here.

[14] It must be remembered that "[a] child, merely on account of his minority, is not beyond the protection of the Constitution." *Bellotti*, 99 S.Ct. at 3043. The need to protect the constitutional right and the unique nature of the abortion decision, especially when made by a minor, required that the State act with particular sensitivity when it legislates to foster parental involvement in this matter. *Bellotti*, 99 S.Ct. at 3047. Although the Supreme Court did not explicitly rule on whether the require-

74. Under state law, doctors would risk charges of unprofessional conduct, La.Rev.Stat.Ann. § 37:1285(13) (West Supp.1979), if they disclosed patient confidences. Public hospital records are confidential, La.Rev.Stat.Ann. § 44:7 (West Supp.1980).

ment of giving notice to the parents of an unmarried minor was unconstitutional, it did rule on a similar issue. In *Bellotti*, the Supreme Court construed the constitutionality of a Massachusetts statute which required that a pregnant minor seeking an abortion must obtain the consent of her parents or obtain judicial approval following notification to her parents. The Supreme Court held that the statute did not satisfy constitutional standards because "it requires parental consultation or notification in every instance, without affording the pregnant minor an opportunity to receive an independent judicial determination that she is mature enough to consent or that an abortion would be in her best interests." *Bellotti*, 99 S.Ct. at 3052 (footnotes omitted). "If she satisfies the court that she is mature and well-informed enough to make intelligently the abortion decision on her own, the court must authorize her to act without parental consultation or consent." *Bellotti*, 99 S.Ct. at 3050. The *Bellotti* parental notice requirement is similar to the one in the instant case. Under the Massachusetts statute, even though a minor woman may obtain a court ordered abortion, she must still inform her parents. Under the Louisiana statute, even though a minor between the ages of fifteen and seventeen years is not required to obtain anyone's consent for an abortion, she too must inform her parents. Applying the rationale of *Bellotti* to the instant case, minors between the ages of fifteen and seventeen years old should be permitted to obtain an abortion without any requirement of parental notice or consultation. Therefore, the Court will strike La.Rev.Stat.Ann. § 40:1299.35.5(A), because it imposes an undue burden upon the exercise of the right to obtain an abortion of unmarried women between the ages of fifteen and seventeen years.

The Court notes that there may also exist constitutional problems with La.Rev.Stat. Ann. § 40:1299.35 [75] which repeats the parental notice requirement and details its procedure. However, La.Rev.Stat.Ann. § 40:1299.35, enacted a week after La.Rev. Stat.Ann. § 40:1299.35.5, has not been challenged by plaintiffs and is not properly before the Court at this time. Thus, the Court will refrain from deciding the constitutionality of La.Rev.Stat.Ann. § 40:1299.-35. It is therefore unnecessary for the Court to consider whether the statutes are vague because La.Rev.Stat.Ann. § 40:1299.-35.5(A) applies to unmarried women under the age of eighteen years, and La.Rev.Stat. Ann. § 40:1299.35 applies to unemancipated minors. The Court has reviewed all sections of the Act as if the language of La. Rev.Stat.Ann. § 40:1299.35.5, dealing with guardian or parental notice and consent, had been struck.

INFORMED CONSENT: LA.REV.STAT. ANN. § 40:1299.35.6 (WEST SUPP.1979) [76]

This section of the Act provides: "An abortion otherwise permitted by law shall

75. La.Rev.Stat.Ann. § 40:1299.35 states:

Informing parents of impending abortion for minor Before any abortion is performed on an unemancipated minor the person performing said abortion shall require written proof that at least one parent or the legal guardian of the unemancipated minor has been given at least seventy-two hours notice of the minor's intention to obtain an abortion. The written proof required will be in the form of a notarized statement of the parent or legal guardian attesting to the fact that he or she was informed by the unemancipated minor of her intention to obtain an abortion. Said statement will also affirmatively attest to the date and time that such notice was received. If the parent or guardian refuses to execute such affidavit, the person performing the abortion shall require an affidavit of an adult who shall attest to the fact of notification to the parent or legal guardian, the date and time thereof, and that said parent or legal guardian refused to execute an affidavit regarding the notice received. The person performing the abortion will maintain for a period of at least five years the written proof required herein and will make it available for inspection by representatives of all public health and law enforcement agencies. Any violation of this statute will be punishable by a maximum fine of five thousand dollars or imprisonment for ninety days or both.

76. La.Rev.Stat.Ann. § 40:1299.35.6(A)-(D) states:

A. An abortion otherwise permitted by law shall be performed or induced only with the

be performed or induced only with the informed written consent of the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with R.S. 40:1299.35.5 [Notice and Consent], given freely and without coercion." La.Rev.Stat.Ann. § 40:1299.35.6 (A) (West Supp.1979). La.Rev.Stat.Ann. § 40:1299.35.6(B) consists of facts a woman's physician must communicate to insure that the woman's consent is an informed consent. The physician is also required to provide the patient with information concerning the risks of pregnancy and abortion. Finally, this section requires that the pregnant woman sign a copy of a consent form.

[15, 16] The duty "to disclose the risks and alternatives of proposed treatment are not innovations in American law. . . . The root premise jurisprudentially is that '[e]very human being of adult years and sound mind has a right to determine what

informed written consent of the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with R.S. 40:1299.35.5, given freely and without coercion.

B. In order to insure that the consent for an abortion is truly informed consent, an abortion shall be performed or induced upon a pregnant woman only after she, and one of her parents or her legal guardian whose consent is required in accordance with R.S. 40:1299.35.5(B) herein, have been orally informed by her attending physician of the following facts and have signed a consent form acknowledging that she, and the parent or legal guardian when applicable, have been informed as follows:

1. That according to the best judgment of her attending physician she is pregnant.

2. The number of weeks elapsed from the probable time of the conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period or after a history and physical examination and appropriate laboratory tests.

3. That the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members.

4. That her unborn child may be viable and thus capable of surviving outside of her womb, if more than twenty-two weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion.

5. That abortion is a major surgical procedure which can result in serious complications, including hemmorrhage [sic] perforated uterus, infection, menstrual disturbances, sterility and miscarriages and prematurity in subsequent pregnancies, and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

6. That numerous public and private agencies and services are available to provide her with natural family planning and artificial birth control information, and that her physician will provide her with a list of said agencies and the services available.

7. That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption, and that her physician will provide her with a list of such agencies and services.

8. That locations of public mental health agencies shall be made available to the patient if and when post-partum psychological damage requires professional attention.

C. At the same time the attending physician provides the information required by Paragraph B of this Section, he shall, at least orally, inform the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with R.S. 40:1299.35.5 herein, of the particular risks associated with her own pregnancy and the abortion technique to be employed including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery, and shall in addition provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or to carry her pregnancy to term.

D. The attending physician performing or inducing the abortion shall provide the pregnant woman, or one of her parents or legal guardian signing the consent form where applicable, with a duplicate copy of the consent form signed by her and one of her parents or her legal guardian where applicable, in accordance with Paragraph B of this Section.

shall be done with his own body . . . .' True consent . . . is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." *Karp v. Cooley*, 493 F.2d 408, 419 (5th Cir.), *cert. denied*, 419 U.S. 845, 95 S.Ct. 79, 42 L.Ed.2d 73 (1974), *quoting Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J.).[77] Informed consent involves the fiduciary[78] nature of the doctor-patient relationship as well as the "basic right of self-determination"[79] that governs potential invasions of physical integrity. The aim is to encourage awareness in the patient's mind of the risks associated with a medical procedure and to obtain his assent to encountering those risks. "The doctrine of informed consent . . . promotes individual autonomy and integrity of the patient; it encourages him to engage in rational decision-making; and it enhances health care delivery by increasing doctor-patient communication and reducing physician liability."[80] The appellation "informed consent" is somewhat misleading because the actual emphasis is on the physician's duty to *inform* his patient rather than on the patient's understanding of the physician's explanation. *Karp*, 493 F.2d at 420 n.14. Therefore, the general rule is that all risks need not be disclosed.[81] Even jurisdictions

77. For a general review of the doctrine, *see* articles cited in Waltz & Scheuneman, *Informed Consent to Therapy*, 64 N.W.U.L.Rev. 628, n.1 (1970) [hereinafter cited as *Informed Consent*].

78. Gauvey *et al.*, *Informed and Substitute Consent to Health Care Procedures: A Proposal for State Legislature*, 15 Harv.J.Legis. 431, 438 (1978) [hereinafter cited as *Informed & Substitute Consent*]. The ideal picture is of a doctor who engages in a thoughtful discussion with the patient. "In fact, this may not be the physician's way. He will probably engage in a measure of salesmanship to persuade his patient to consent, particularly when time is short and treatment must be commenced quickly. The permissible limits of this sort of persuasion are difficult to trace, short of the point where it might legitimately be said that the patient's consent was actively induced by the physician when, because of the risks involved, he would not otherwise have consented. Such coercion will always be difficult to prove, since subtle questions of the psychological effect of the physician's actions are involved." *Informed Consent*, at 645-46 (1970) (footnote omitted).

79. Shapiro, *The Abortion Alternative & the Patient's Right to Know*, 1978 Wash.U.L.Q. 167, 175 (1978).

80. *Informed & Substitute Consent*, at 438.

81. In *Karp v. Cooley*, 493 F.2d 408, 419 n.11 (5th Cir. 1974), *cert. denied*, 419 U.S. 845, 95 S.Ct. 79, 42 L.Ed.2d 73 (1974), the Fifth Circuit stated:

> [T]he majority rule . . . compels a physician to disclose facts which a reasonable medical practitioner in a similar community and of the same school of medical thought would have disclosed to his patient regarding the proposed treatment. . . . A "minority" rule has developed requiring disclosure of all "material" information which a reasonable man in the situation which the physician knew or should have known to be the plaintiff's would deem significant in making a decision to undergo the recommended treatment.
>
> (Citations omitted.)

Louisiana has adopted the minority rule. *See Hanks v. Drs. Ranson, Swan & Burch, Ltd.*, 359 So.2d 1089, 1092-93 (La.App. 3rd Cir. 1978), *writ denied*, 360 So.2d 1178 (1978); *Percle v. St. Paul Fire & Marine Ins. Co.*, 349 So.2d 1289, 1299-1300 (La.App. 1st Cir. 1977).

"There is no bright line separating the significant [risk] from the insignificant; the answer in any case must abide a rule of reason. . . . The disclosure doctrine, like others marking lines between permissible and impermissible behavior in medical practice, is in essence a requirement of conduct prudent under the circumstances." *Canterbury v. Spence*, 150 U.S. App.D.C. 263, 279, 464 F.2d 772, 788 (D.C.Cir. 1972).

Commentators have discussed the question of disclosing *all* risks in terms of a self-evident proposition. "A physician probably need not disclose every risk which *could* be disclosed, if only because of the time required to disclose every remote risk. Less than 'total' disclosure will satisfy the law's demands, but how much less?" *Informed Consent*, at 635. For the answer of some courts *see Sawyer v. Methodist Hospital*, 522 F.2d 1102, 1106-7 (6th Cir. 1975) (no need to reveal risk with incidence rate of .013%); *Dunham v. Wright*, 423 F.2d 940, 946 (3rd Cir. 1970); *Niblack v. United States*, 438 F.Supp. 383, 388 (D.Colo.1977) (no need to reveal "insignificant" risk); *Parker v. St. Paul Fire & Marine Ins. Co.*, 335 So.2d 725, 733 (La.App. 2nd Cir. 1976); *writ denied*, 338 So.2d 700 (1976) ("It is not incumbent upon an attending physician to advise a patient as to every conceivable possibility and eventuality

which base informed consent statutes on the broader base of materiality require disclosure only "when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to undergo the proposed therapy." [82]

In *Danforth*, the Supreme Court held that it is both "desirable and imperative" that women make the decision as to whether *or not* to have an abortion "with full knowledge of its nature and consequences." *Danforth*, 428 U.S. at 67, 96 S.Ct. at 2840. La.Rev.Stat.Ann. § 40:1299.35.6(A) is successfully directed and limited to that end. Unfortunately, portions of La.Rev.Stat. Ann. § 40:1299.35.6(B) are not as well drafted. The *Danforth* opinion [83] did not inquire into the *basis* of informed consent:

> One might well wonder, offhand, just what "informed consent" of a patient is. The three Missouri judges who composed the three-judge District Court, however, were not concerned, and we are content to accept, as the meaning, the giving of information to the patient as to just what would be done and as to its consequences. *To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession.*
>
> *Danforth*, 428 U.S. at 67 n.8, 96 S.Ct. at 2840 n.8 (emphasis added).

Flexible informed consent statutes leaving specific details to the doctor's best judgment have been upheld.[84] However, analysis of La.Rev.Stat.Ann. § 40:1299.35.6(B) reveals constitutional infirmities closely analogous to those discussed in *Wynn v. Scott*, 449 F.Supp. 1302 (N.D.Ill.1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979).[85]

[17] *La.Rev.Stat.Ann. § 40:1299.35.6(B)(3)*: The Court has already held [86] that the most advanced method of determining fetal age has an error rate of plus or minus two weeks. During the first trimester,

. . . ."); *Hanks*, 359 So.2d at 1092; *Delaune v. Davis*, 316 So.2d 7, 11-12 (La.App. 1st Cir. 1975); *Informed Consent*, at 638 n.37 and cases cited therein. *See also* 45 C.F.R. § 46.103(C)(1)-(3)(1978).

82. *Informed Consent* at 640.

83. The statute under discussion in *Danforth* stated:

> Section 3. No abortion shall be performed prior to the end of the first twelve weeks of pregnancy except.
>
> * * * * * *
>
> (2) After the woman, prior to submitting to the abortion, certifies in writing her consent to the abortion and that her consent is informed and freely given and is not the result of coercion.
>
> *Planned Parenthood of Cent. Mo. v. Danforth*, 392 F.Supp. 1362, 1365 (E.D.Mo.1975), *aff'd in part, rev'd in part and remanded*, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976).

84. *See Hodgson v. Lawson*, 542 F.2d 1350, 1355-56 (8th Cir. 1976), *rev'g* 378 F.Supp. 1008, 1013 (D.Minn.1974) ("after a full explanation of the procedures and effect of the abortion"); *Wolfe v. Schroering*, 541 F.2d 523, 526 (6th Cir. 1976) ("inform the expectant mother of the reasonably possible physical and mental consequences of the performance of the abortion or the nonperformance of the abortion."); *Mobile Women's Medical Clinic, Inc. v. Bd. of Comm'rs.*, 426 F.Supp. 331, 335 (S.D.Ala.1977) ("a statement indicating informed consent"); *Doe v. Deschamps*, 461 F.Supp. 682, 683 (D.Mont.1976) ("the nature of the surgical procedure, its consequences and alternatives, and that the patient has voluntarily consented to the procedure.").

> One semi-restrictive statute was upheld in *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F.Supp. 554 (E.D.Pa.1975), *aff'd sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed.2d 1205 (1976), *see* n.10 *supra*. However, the only discussion of the provision occurred in a dissenting opinion, 401 F.Supp. at 583, and a concurring opinion that took issue with the dissenting opinion, 401 F.Supp. at 586. The Supreme Court affirmed without opinion.

85. The Illinois abortion statute under consideration in *Wynn v. Scott* required that a woman be informed of:

> (a) The physical competency of the fetus at the time the abortion is to be performed, such as, but not limited to, what the fetus looks like, the fetus [sic] ability to move, swallow, and its physical characteristics;
>
> (b) The general dangers of abortion, including, but not limited to, the possibility of subsequent sterility, premature birth, live-born fetus and other dangers; . . .
>
> 449 F.Supp. at 1316.

86. *See* nn.47 & 49, *supra*, and accompanying text.

when the vast majority of abortions occur,[87] development of the fetus is extremely rapid.[88] Since a doctor can not pinpoint the exact age of a fetus, the doctor will have to describe fetal development over a five week period, the week the doctor *thinks* is accurate, plus two weeks on either side in case of error. The statute, however, does not give the doctor that option. Instead, it *requires* him, under threat of criminal penalties, to describe the fetus "at the gestational point of development at which time the abortion is to be performed . . . ." This can not be done by a conscientious physician. Even if he protects himself by including an extra two weeks on either side, he still has no assurance that under the statute he has included sufficient detail.

Furthermore, the requirement that physicians inform women of specific items in a manner "including but not limited to", is "both overly vague and overly specific." *Wynn v. Scott*, 449 F.Supp. at 1317.

> The physician does not have fair warning of what is required. It is unclear whether the state could prosecute a physician for failure to warn the woman of a danger not included in the list. On the other hand, the very specificity . . . [required] places the physician in the "straitjacket" condemned in *Danforth*.
>
> *Wynn*, 449 F.Supp. at 1317.

The doctor's right and ability to practice medicine "free from the imposition of arbitrary restraints" will be injured no matter how he attempts to comply with the statute. *Greco v. Orange Memorial Hospital Corp.*, 513 F.2d 873, 875 (5th Cir.), *cert. denied*, 423 U.S. 1000, 96 S.Ct. 433, 46 L.Ed.2d 376 (1975).

Finally, La.Rev.Stat.Ann. § 40:1299.35.6(B)(3) is also unconstitutional because it forces the doctor to state that "the unborn child is a human life from the moment of conception . . . ." This statement disregards *Roe*'s finding that the state may not make a determination that life begins at the moment of conception:[89] "Since the fetus is not a person, . . . neither is it a child." *Poe v. Gerstein*, 517 F.2d 787, 796 (5th Cir. 1975), (citing *Roe*, 410 U.S. at 156-58, 93 S.Ct. at 728-29), *aff'd sub nom. Gerstein v. Poe*, 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed.2d 1205 (1976). *See also Carver v. Hooker*, 501 F.2d 1244, 1246 n.2 (1st Cir. 1974); *Doe v. Israel*, 482 F.2d 156, 159 (1st Cir. 1973).

[18] *La.Rev.Stat.Ann. § 40:1299.35.6(B)(4)*: This section includes the impermissible presumption[90] that viability occurs twenty-two weeks after conception. Although the section begins with the permissive language "may be viable", it concludes with language that asserts an obligation to a "viable unborn child." Since it is impossible[91] for a doctor to tell whether a fetus is viable until *after* birth,[92] the statute is based on the assumption that the fetus is viable twenty-two weeks after conception. If it were not, the doctor could not tell when his legal obligation to the fetus arose. La.Rev.Stat.Ann. § 40:1299.35.6(B)(4) is unconstitutional because it is based on an irrebuttable presumption of viability. *Colautti*, 99 S.Ct. at 686.

La.Rev.Stat.Ann. § 40:1299.35.6(B)(5): This section mandates that physicians make the following statements to patients to insure "truly informed consent":

> That abortion is a major surgical procedure which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriages and prematuri-

87. P. Ex. 14, at 3.

88. Transcript of Dr. Jay Katz [hereinafter cited as Katz Tr.], at 34.

89. "Texas urges that, . . . life begins at conception and is present throughout pregnancy . . . . . [T]he unborn have never been recognized in the law as persons in the whole sense." *Roe*, 410 U.S. at 159, 162, 93 S.Ct. at 730-31.

90. *See* discussion of § 40:1299.35.4(B), nn.47-55 *supra* and accompanying text.

91. For a discussion of the difficulty in determining fetal age, *see* nn.47 & 49, *supra* and accompanying text.

92. For a discussion of § 40:1299.35.4(B), nn.47-55, *supra*.

ty in subsequent pregnancies, and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

La.Rev.Stat.Ann. § 40:1299.35.6(B)(5) (West Supp.1979).

In determining the constitutionality of such a provision the Court must balance the State's legitimate interest in maternal health against the patient's right to consult her physician without state interference. The Eighth Circuit Court of Appeals has recently weighed these two competing interests:

> The legitimate state interest at stake here is protecting the mother by requiring an informed consent to the abortion decision. The Court in *Danforth* held that Mo.Ann.Stat. § 188.020(2) (Vernon 1978), Missouri's informed consent provision, was not "in itself an unconstitutional requirement. The decision to abort, indeed, is an important, and often stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." *Planned Parenthood v. Danforth, supra*, 428 U.S. at 67, 96 S.Ct. at 2840. *But the Supreme Court did not hold that a state may require physicians to provide to each patient any and all information required by the state, regardless of its legality, truth, constitutionality or medical advisability.* "[W]e are content to accept, as the meaning [of informed consent], the giving of information to the patient as to just what would be done and as to its consequences. *To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession.*" *Planned Parenthood v. Danforth, supra*, 428 U.S. at 67 n.8, 96 S.Ct. at 2840. *Freiman v. Ashcroft*, 584 F.2d 247, 251 (8th Cir. 1978) (emphasis added), *aff'd*, 440 U.S. 941, 99 S.Ct. 1416, 59 L.Ed.2d 630 (1979).

The Court holds that La.Rev.Stat.Ann. § 40:1299.35.6(B)(5) places physicians in "an undesired and uncomfortable straitjacket" *Danforth*, 428 U.S. at 67 n.8, 96 S.Ct. at 2840 n.8, because the physician is permitted no discretion as to what type of information should be conveyed to each patient. Further this section forces the physician to communicate to his patients questionable factual information.[93] The evidence demonstrated, and the Court so finds, that in the overwhelming number of cases, abortion is a *minor* surgical procedure, not a major surgical procedure.[94]

93. Drs. Tietze, Crist, Soderstrom and Jackson all testified as to the lack of any evidence that abortion causes either miscarriages or prematurity in subsequent pregnancies. Tietze Tr. at 112–20; Crist Tr. at 69–71; Soderstrom Tr. at 22, 30–1; Jackson Tr. at 201; Levin Aff. at ¶ 24. The Court did not find Dr. Wilke's testimony in this area to be credible. He repeatedly denounced studies published in reputable medical journals as faulty without stating any basis for such opinions. Benshoof Aff., ¶¶ 43, 44. The so-called Klinger study, on which he relied, was discredited by Dr. Tietze insofar as it has any applicability to the United States. Tietze Tr. at 120–4. His testimony, Benshoof Aff., ¶ 44, on a Japanese study, itself of questionable validity (Tietze Tr. at 126), was inaccurate. *See* Intervenor's [now Amicus Curiae] Ex. 35; Tietze Tr. at 127. It is questionable whether either the Czechoslovakian or the Finnish study to which he referred, Benshoof Aff., ¶ 44, actually exists. Tietze Tr. at 127–30.

Dr. Dickey was a credible witness. His report to the Food & Drug Administration referred to "*[r]eports* of increased sterility and a high incidence of mid-trimester abortion and immature and premature delivery in subsequent pregnancies following mechanically-induced abortion [that] have existed for some time." Dickey Tr. at 159 (emphasis added). However, the three studies he cited dealt with infection and risks of uterine laceration or cervical incompetence, three risks plaintiffs acknowledge exist. He did not have a working familiarity with the most recent studies, Dickey Tr. at 173–75, nor with certain relevant underlying factors of the studies which he did cite, Dickey Tr. at 175.

94. Tietze Tr. at 110; Soderstrom Tr. at 12–20; Jackson Tr. at 199–200; Wood Tr. at 255; Okpalobi Tr. at 308–309; Levin Aff. ¶ 66; Williams Tr. at 154–55; Dickey Tr. at 178. Dr. Moorman stated it depended on how you define "major." Moorman Tr. at 151–52. Some abortions, such as those on high risk patients, and some *forms* of abortion, such as hysterotomy, are major surgery. Williams Tr. at 154 (entry of a major body cavity). However, under the Act *all* abortions must be so described. To

[19] Other courts have also weighed the State's competing interest in informed consent for abortion procedures against the patient's right to consult her physician without state interference. In *Akron Center for Reproductive Health, Inc. v. Akron*, 479 F.Supp. 1172 (N.D.Ohio 1979), that Court construed an Akron ordinance regulating abortion. The Akron ordinance required physicians to make the identical disclosures contained in the instant section. The Ohio Court found that the Akron ordinance was impermissible:

> The Court has no doubt that the state could constitutionally require that all abortion patients be counselled, either by their attending physician or another individual having specified minimum qualifications. *The state cannot, however, go beyond that to specify what each patient must be told. That determination must be left to the individual counselor based upon the needs of the particular patent.* Otherwise, the physician is being placed in the "undesired and uncomfortable straitjacket" warned against by the Supreme Court. This is not impermissible because of any perceived interference with rights of the physician. Rather, it is impermissible because it interferes with the woman's right to consult a physician who is free from such state interference.
>
> *Akron Center for Reproductive Health, Inc. v. Akron*, 479 F.Supp. at 1203 (N.D. Ohio 1979) (footnotes omitted) (emphasis added).

The Court, therefore, similarly holds that La.Rev.Stat.Ann. § 40:1299.35.6(B)(5) (West Supp.1979) is unconstitutional.

[20] *La.Rev.Stat.Ann. § 40:1299.35.6(B)(6)*: Informed consent is designed to foster patient knowledge about the risks and benefits of a particular procedure. "Informed consent requires an exchange of information between the physician and patient which culminates in a decision made by the patient based on this information." Gauvey, *et al., Informed and Substitute Consent to Health Care Procedures: A Proposal for State Legislatures*, 15 Harv.J.Legis. 431, 439 (1978) (hereinafter *Gauvey*). The instant section requires the physician to communicate information to the patient dealing with natural and artificial birth control. The Court holds that information concerning birth control techniques is not rationally related to the giving of informed consent for an abortion procedure. At that point in time when a woman decides between abortion and birth, information about birth control techniques does not contribute to an "exchange of information which culminates in a decision made by the patient. . . ." *Gauvey* at 439. La.Rev.Stat.Ann. § 40:1299.35.6(B)(6) is unconstitutional because it "is not reasonably related to the purpose of informed consent." *Freiman v. Ashcroft*, 584 F.2d 247, 251 (8th Cir. 1978), *aff'd*, 440 U.S. 941, 99 S.Ct. 1416, 59 L.Ed.2d 630 (1979).

[21] *La.Rev.Stat.Ann. §§ 40:1299.35.6(B)(7), (8)*: These sections require the physician to inform the patient of available social services should the patent opt for childbirth instead of abortion. La.Rev.Stat.Ann. §§ 40:1299.35.6(B)(7), (8) are somewhat vague because they refer to unspecified "numerous public and private agencies" and "public mental health agencies." However, physicians can easily supply patients with standard printed material listing public social service agencies which offer assistance to women during pregnancy and after birth, located in the same area as the physician's office. The Court holds that providing information to patients concerning social services available to a pregnant woman or a recent mother is rationally related to the giving of an informed consent

describe a first trimester abortion done by suction aspiration as "something that carries a high risk" in which "an immediate life-threatening complication *would* occur, which would require extensive surgical treatment" is inaccurate. Tietze Tr. at 110 (emphasis added). *See Roe*, 410 U.S. at 148–49, 93 S.Ct. at 724 (dis-

to undergo an abortion. Accordingly, the Court will sustain these sections.[95]

[22] *La.Rev.Stat.Ann. §§ 40:1299.35.6(C), (D):* The Court holds that these sections are reasonably related to the giving of an informed consent. Providing relevant information based on a physician's "own medical judgment," *see* La.Rev.Stat.Ann. § 40:1299.35.6(C), is essentially the definition of informed consent. Requiring the patient to sign the consent form protects both the patient and the physician. *See* La.Rev.Stat.Ann. § 40:1299.35.6(D). Except for the language used in both sections, "or one of her parents or legal guardian," *see* pp. 201–205, *supra*, the Court holds that La.Rev.Stat.Ann. §§ 40:1299.35.6(C), (D) are constitutional.

WAITING PERIOD: LA.REV.STAT. ANN. § 40:1299.35.7 (WEST SUPP.1979)

This section[96] requires that a physician must wait at least twenty-four hours after the patient signs the required informed consent form before performing an abortion. The Court holds that this requirement places a significant and unconstitutional burden upon a woman's ability to obtain an abortion.

A twenty-four hour waiting period was upheld in *Wolfe v. Schroering*, 541 F.2d 523 (6th Cir. 1976). *Accord, Akron Center for Reproductive Health, Inc. v. Akron*, 479 F.Supp. at 1204–1205 (N.D.Ohio 1979). In *Wolfe* the Court of Appeals stated that "a delay of 24 hours could not result in a transition from the first into second trimester, or from the second trimester into 'viability.' . . . Nor do plaintiffs claim that the 24-hour waiting period significantly burdens the abortion process." 541 F.2d at 526 (citation omitted). However, this Court finds that plaintiffs in the instant case have proved that the Act's waiting period may result in such trimester shifts in a significant number of cases and will be unconstitutionally burdensome to the abortion process.

All reported abortions in Louisiana are performed either in Baton Rouge or New Orleans.[97] Eight per cent of the patients are from out of state.[98] A majority of the patients at the Delta Clinic in New Orleans are not from the city itself.[99] Because there are a limited number of doctors presently doing abortions in Louisiana, women are presently traveling significant distances to obtain them. To require women to wait an additional twenty-four hours will mean that many women will either have to stay over an extra day or have to make a second trip. In a significant number of cases, delays will be three to five days because of weekends and because some clinics are not open five days a week. Such delays could carry a woman into another trimester. Furthermore, even a twenty-four hour delay will increase the risk to a pregnant woman's health.[100] *Accord, Womens Services, P. C. v. Thone*, 483 F.Supp. 1022 at 1050 (D.Neb.1979) (With reference to a forty-eight hour waiting period, the Court found that "the increased risk [to a pregnant woman's health] to be substantial."); *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft*, 483 F.Supp. 679 at 696 (W.D.Mo.1980).

cussing data on safety of first trimester abortions); Crist Tr. at 16–17.

95. *Contra, Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft*, 483 F.Supp. 679 at 697 (W.D.Mo.1980).

96. La.Rev.Stat.Ann. § 40:1299.35.7 states:
No physician shall perform or induce an abortion upon a pregnant woman until twenty-four hours have elapsed from the time the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with R.S. 40:1299.35.5(B) herein, have signed the consent form required by R.S. 40:1299.35.6, and the physician so certifies in writing that such time has elapsed.

97. P. Ex. 34D.

98. P. Ex. 34B.

99. Cottle Tr. at 57–58 (between 60% and 70% of Delta's patients do not reside in New Orleans).

100. *See* nn.35 & 39, *supra*.

[23, 24] Access to the abortion procedure is a fundamental right. *Roe*, 410 U.S. at 154, 93 S.Ct. at 727. A regulation limiting this right may be justified only by a compelling state interest and must be narrowly drawn. *Roe*, 410 U.S. at 155, 93 S.Ct. at 727. Unlike the requirement of informed consent, the requirement of a waiting period "is a direct obstacle" to having an abortion. *Womens Services, P. C. v. Thone, supra*, at 1050; *Leigh v. Olson*, No. A3-79-78 (D.N.D. July 9, 1979) (order granting preliminary injunction), at 4. A mandatory delay [101] "means that, even after a decision to have an abortion has been made, irrespective of how carefully and thoughtfully, the woman must wait for [twenty-four] hours . . . . That is a burden." *Leigh, supra*, slip op. at 4. During the first trimester, "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." *Roe*, 410 U.S. at 164, 93 S.Ct. at 732. Once a woman has given her informed consent, her decision has been made. Apparently, the state interest is that a woman seeking an abortion should have time to consider her decision after signing the consent form. "While this may be legitimate, it is not sufficiently compelling to justify the burdens imposed by this direct obstacle to abortion." *Womens Services, P. C. v. Thone*, 483 F.Supp. at 1050. The Court therefore holds that La.Rev.Stat.Ann. § 40:1299.35.7 is an unconstitutional infringement upon a woman's ability to obtain an abortion, thus restricting the woman's constitutional right of privacy.

RECORDS: LA.REV.STAT.ANN. § 40:1299.35.8 (WEST SUPP.1979)

This section [102] requires that essentially all of a doctor's paperwork, as well as all forms required by the Act, be kept by the doctor for seven years. The Court holds that the requirements of this section are vague, burdensome, and will have a "legally significant impact or consequence on the abortion decision [and] on the physician-patient relationship." *Danforth*, 428 U.S. at 81, 96 S.Ct. at 2846.

La.Rev.Stat.Ann. § 40:1299.35.8 differs significantly from the statute in *Danforth*, 428 U.S. at 79–81, 96 S.Ct. at 2845–2846, which required that state supplied health forms be kept for statistical purposes for seven years. The requirements of the Louisiana provision are more stringent: not only must doctors keep such statistical forms, they must also keep "records, including admission and discharge notes, histories, results of tests and examinations, nurses' work sheets, etc." No other medical or surgical procedure, in Louisiana, comparable or otherwise, is regulated in this fashion.

La.Rev.Stat.Ann. § 40:1299.35.8 is impermissibly vague because it fails to give a specific list of the documents which a doctor is required to keep. The "records" of a patient may be defined broadly, to include every scrap of paper and note taken, or narrowly, to include only the patient's chart and other formal documents. When attempting to comply with a criminal statute that begins with the word "including" and ends with the abbreviation "etc.", a doctor cannot safely determine what he may throw away and what he must keep in his workfile. The only limits placed on what records a doctor ought to keep are those of the local prosecutor's imagination. This is impermissible in a criminal statute.

Nor can the state justify this section by arguing that the doctor's work papers are necessary for statistical purposes.

101. The Court notes that La.Rev.Stat.Ann. § 40:1299.35.12 (West Supp.1979) provides an exception from the requirements of La.Rev.Stat.Ann. § 40:1299.35.7 in an emergency.

102. La.Rev.Stat.Ann. § 40:1299.35.8 states:

> All abortion facilities and hospitals in which abortions are performed or induced shall keep records, including admission and discharge notes, histories, results of tests and examinations, nurses' work sheets, etc. and shall further keep a copy of all written certifications herein provided for as well as a copy of records of constructive work consent forms, abortion records, and complication reports provided for in R.S. 40:1299.35.5, 1299.35.6 and 1299.35.10. Such records shall be maintained in the permanent files of the abortion facility for a period of not less than seven years.

> [M]aintenance of records indeed may be helpful in developing information pertinent to the preservation of maternal health.
>
> . . . . .
>
> . . . . Recordkeeping of this kind, if not abused or overdone, can be useful to the State's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment.
>
> *Danforth*, 428 U.S. at 80, 81, 96 S.Ct. at 2846 (footnote omitted).

However, the amalgam of charts, notes, worksheets, and patient histories in a typical patient's folder is not in any kind of order that would allow the data to be analyzed systematically. It is not gathered for that purpose. Rather, it is used to assemble information about a particular patient and may well include items revealed in strict confidence on subjects dealing only tangentially with the abortion procedure. Such data will be irrelevant to any State health survey. Knowledge that such intimate files, marked with her name, will be kept for seven years and will be open to inspection by the State at any time will have a negative impact on what a woman reveals to her doctor. Instead of giving him an accurate medical history, she might well hide previous abortions, past incidents of venereal disease, or other data about her sexual activity that might be embarrassing but extremely relevant to a doctor's treatment and advice. This is a clear constraint on the development of a candid doctor-patient relationship. Indeed, many women unwilling to risk disclosure of their names might not seek a legal abortion. *See, Wynn*, 449 F.Supp. at 1328. The Court holds that the requirement that all files on a patient be kept for inspection will have a significant impact on the abortion decision, its effectuation, and upon the physician-patient relationship.

[25] Furthermore, La.Rev.Stat.Ann. § 40:1299.35.8 is a burden on the doctor's right to practice medicine. Keeping state supplied forms, perhaps two or three sheets per patient, that are anonymous, that can be compiled easily while taking the patient's history and that are directed solely towards a legitimate state interest, such as protection of maternal health, may fall within the limits of permissible state regulation. *Wynn*, 449 F.Supp. at 1328. However, requiring that a doctor keep all papers on which he has ever scratched a note about a patient, and keep them intact for seven years, as office space and personnel change, will "accomplish, through the sheer burden of recordkeeping detail, what [the Supreme Court has] held to be an otherwise unconstitutional restriction." *Danforth*, 428 U.S. at 81, 96 S.Ct. at 2047. It will not only prevent doctors from purging their files of irrelevant papers so that storage will be less cumbersome, it will also force those who wish to protect their patients' privacy to separate a long term patient's "abortion" record from her "regular" record. This task may be impossible if the abortion takes place in conjunction with some other procedure, such as a hysterectomy. Even where it is possible, it will require a doctor to keep duplicate records on every patient which will cost the doctor, and eventually the patient, additional money for duplication, cross-referencing, storage, and personnel. The Court therefore holds that La.Rev.Stat. Ann. § 40:1299.35.8 is an unconstitutional burden on both a doctor's right to practice medicine and a woman's right of privacy.

INSPECTION: LA.REV.STAT.ANN. § 40:1299.35.9 (WEST SUPP.1979)

This section [103] requires that both medical records and abortion facilities shall be open

103. La.Rev.Stat.Ann. § 40:1299.35.9 states:

> A. The medical records and the physical facilities of all abortion facilities and hospitals in which abortions are performed shall be open to inspection at any time by the Department of Health and Human Resources for purposes of gathering statistical data and insuring compliance with the provisions of R.S. 40:1299.35.1–40:1299.35.18.
>
> B. The medical records of abortion facilities and hospitals in which abortions are performed and all information contained therein shall remain confidential and shall be used by the Department of Health and Human Re-

for inspection at any time by the Department of Health and Human Resources and that the department must inspect all such locations at least once every six months. It further provides that the medical records shall remain confidential. Abortion facilities include clinics, physician's offices, or any other place or facility where an abortion is performed. The Court holds that this section violates the Fourth Amendment:

> The basic purpose of the [Fourth] Amendment, as recognized in countless decisions of [the Supreme] Court, is to safeguard the privacy and security of individuals against arbitrary invasions by governmental officials. The Fourth Amendment thus gives concrete expression to a right of the people which "is basic to a free society."
>
> . . . . . .
>
> . . . [O]ne governing principle, justified by history and by current experience, has consistently been followed: except in certain carefully defined classes of cases, a search of private property without proper consent is 'unreasonable' unless it has been authorized by a valid search warrant.
>
> *Camara v. Municipal Court*, 387 U.S. 523, 528, 87 S.Ct. 1727, 1730–31, 18 L.Ed.2d 930 (1967) (citations omitted) (housing code inspection).

This principle applies whether the property is residential or commercial. *Marshall v. Barlow's Inc.*, 436 U.S. 307, 98 S.Ct. 1816, 56 L.Ed.2d 305 (1978) (OSHA inspections) (*Marshall*); *See v. City of Seattle*, 387 U.S. 541, 87 S.Ct. 1737, 18 L.Ed.2d 943 (1967) (fire inspection). The Supreme Court explained:

> If the government intrudes on a person's property, the privacy interest suffers whether the government's motivation is to investigate the violations of criminal laws or breaches of other statutory or regulatory standards. It therefore appears that unless some recognized exception to the warrant requirement applies, *See v. City of Seattle, supra*, would require a warrant to conduct the inspection sought in this case.
>
> *Marshall*, 436 U.S. at 312–13, 98 S.Ct. at 1820.

Defendants assert that the recognized exception for "pervasively regulated business[es]" applies to abortion facilities. *United States v. Biswell*, 406 U.S. 311, 316, 92 S.Ct. 1593, 1596, 32 L.Ed.2d 87 (1972). Defendants contend that abortion facilities are part of an industry with "such a history of government oversight that no reasonable expectation of privacy . . . could exist for [the] proprietor . . . ." *Marshall*, 436 U.S. at 313, 98 S.Ct. at 1821 (citation omitted). The Supreme Court in *Marshall* cited liquor and firearms as two industries in which a businessman "has voluntarily chosen to subject himself to a full arsenal of governmental regulations." *Marshall*, 436 U.S. at 313, 98 S.Ct. at 1821.

At first, defendant's argument sounds persuasive when applied to the medical profession. The State regulates the initial licensing of doctors[104] and various health facilities.[105] The State conducts some inspections.[106] The practice of medicine is a privilege and that privilege may be revoked for any number of reasons, ranging from habitual drunkenness to repeated overcharging of patients. La.Rev.Stat.Ann.

> sources only for the purposes set forth in Paragraph A of this Section.
>
> C. Licensing workers of the Department of Health and Human Resources shall physically inspect all abortion facilities at least once every six months to insure compliance with the provisions of R.S. 40:1299.35.1 through 40:1299.35.18 and all laws of the state of Louisiana and its respective political subdivisions concerning health and sanitation.

104. La.Rev.Stat.Ann. § 37:1261 *et seq.* (West 1974 & West Supp.1979).

105. La.Rev.Stat.Ann. § 40:2009.3(D)–.35, :2103 (A), (B), :2135, :2139(B) (West 1977 & West Supp.1979). *See* Plaintiffs' Statement of Facts, at 145.

106. La.Rev.Stat.Ann. § 40:2137(B) (West 1977) (ambulatory surgical centers); La.Rev.Stat. Ann. § 40:2009.8 (West 1977) (nursing homes). Note the extensive procedure for evaluating complaints against nursing homes, La.Rev.Stat. Ann. § 40:2009.13–.19 (West Supp.1979).

§§ 37:1285(4), (16) (West Supp.1979). Physicians would seem to be much more closely regulated than the electrical and plumbing installation business discussed in *Marshall*.

Closer examination, however, reveals flaws in defendant's argument. Physicians, surgeons, and midwives are actually self-regulated. Their licensing board, the Louisiana State Board of Medical Examiners, is composed of members "appointed by the governor from a list of names recommended by the Louisiana State Medical Society and the Louisiana Medical Association." La.Rev.Stat.Ann. § 37:1263(B) (West Supp. 1979). Both of these organizations are private, self-perpetuating bodies. Nor can the fact that the state requires a license to practice be dispositive since Louisiana demands a license for over thirty occupations.[107] Nor can it be sufficient to argue that the State has a clear interest in protecting its citizens' health through insuring compliance with the Act:

> [I]t is vigorously argued that the health and safety of entire urban populations is dependent upon enforcement of minimum fire, housing, and sanitation standards, and that the only effective means of enforcing such codes is by routine, systematized inspection of all physical structures. Of course, in applying any reasonableness standard, including one of constitutional dimension, an argument that the public interest demands a particular rule must receive careful consideration. But we think this argument misses the mark. The question is not, at this stage at least, whether these inspections may be made, but whether they may be made without a warrant. . . . [W]hether the authority to search should be evidenced by a warrant . . . depends in part upon whether the burden of obtaining the warrant is likely to frustrate the governmental purpose behind the search.

Camara, 387 U.S. at 533, 87 S.Ct. at 1733.

Inspections designed to insure compliance with this section and to collect statistics do not seem to fall into the category of "prompt inspections, even without a warrant, that the law has traditionally upheld in emergency situations." *Camara*, 387 U.S. at 539, 87 S.Ct. at 1736. It is questionable whether unsanitary conditions, poorly trained personnel, and lack of proper equipment are "amenable to speedy alteration or disguise." *Marshall*, 436 U.S. at 316, 98 S.Ct. at 1822. However, even if they are, "it [is not] immediately apparent why the advantage of surprise would be lost if, after being refused entry, procedures were available for the [agency] to seek an *ex parte* warrant and to reappear at the premises without further notice to the establishment being inspected." *Marshall*, 436 U.S. at 319–20, 98 S.Ct. at 1824. The State has a legitimate interest in reviewing records or in inspecting facilities, "[b]ut the decision to enter and inspect [should] not be the product of the unreviewed discretion of the enforcement officer in the field." *See v. City of Seattle*, 387 U.S. at 545, 87 S.Ct. at 1740.

[26] It is evident that the threat to privacy is of impressive dimensions, affecting both the doctor and his patient. Doctors have a reasonable expectation that their offices and files are private. The medical profession, unlike the liquor industry, has no "long history" of warrantless state inspection. *Colonnade Catering Corp. v. United States*, 397 U.S. 72, 75–76, 90 S.Ct. 774, 776–77, 25 L.Ed.2d 60 (1970) (emphasizing detection of revenue fraud and seizure of stolen goods). Nor is the practice of medicine an industry in which heavy regulation is crucial to assure careful distribution of dangerous weapons, as in the firearms industry. *United States v. Biswell*, 406 U.S. at 315–16, 92 S.Ct. at 1596 (emphasizing prevention of crime). Rather, it is a profession with a history of respect towards the recognized need for privacy in the doctor-patient relationship. Communications with patients, including records, are privileged and may not be disclosed to any third party without the patient's express consent. La.Rev.Stat.Ann. § 13:3734(B) (West Supp. 1979); La.Rev.Stat.Ann. § 15:476 (West

107. *See generally*, La.Rev.Stat.Ann. § 37:1 *et seq.* (West 1977 & West Supp.1979). Among those required to obtain a license are retail florists and barbers.

1967). A patient feels free to reveal data to a doctor only because she knows that it will not be revealed to *anyone* without her permission. Absent such a guarantee of privacy, doctors and their patients cannot realize the desired result of consultation: a discussion free of restraint. The Court finds that the health industry in Louisiana is not a closely regulated industry within the meaning of *Marshall v. Barlow's Inc.*, 436 U.S. 307, 98 S.Ct. 1816, 56 L.Ed.2d 305 (1978). Therefore, the Court holds that La.Rev.Stat.Ann. § 40:1299.35.9 violates the Fourth Amendment because it authorizes warrantless inspections. *Accord, Akron Center for Reproductive Health, Inc. v. Akron*, 479 F.Supp. at 1205 (N.D.Ohio 1979).

REPORTING: LA.REV.STAT.ANN. § 40:1299.35.10 (WEST SUPP.1979)

A.

Paragraph A of this section[108] requires that doctors submit an abortion report on each patient to the Department of Health and Human Resources. Such reports have been upheld when the patient's confidentiality is protected. "The acquisition of data is essential to the advancement of medical knowledge. These provisions establish reporting procedures for statistical purposes only . . . ." *Planned Parenthood of Cent. Mo. v. Danforth*, 392 F.Supp. 1362, 1374 (E.D.Mo.1975), *aff'd in part, rev'd in part and remanded*, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976). The Supreme Court in *Danforth* rejected the argument that such reports are improper because they "significantly differ from those imposed with respect to other, and comparable, medical or surgical procedures," *Danforth*, 428 U.S. at 80–81, 96 S.Ct. at 2846. The fact that several items of data are required is not enough to render the list unconstitutionally burdensome. "The information can be assembled quickly and recorded on forms." *Wynn v. Scott*, 449 F.Supp. 1302, 1327 (N.D.Ill.1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979). Examination of the forms presently used at two of the plaintiff clinics indicate that almost all the information is already being collected.[109]

[27] The only problem presented in La.Rev.Stat.Ann. § 40:1299.35.10(A) is its requirement that doctors provide the "[z]ip code or residence of [the] pregnant woman." La.Rev.Stat.Ann. § 40:1299.35.10(A)(4) (West Supp.1979). At least one other court has confined "legal residence" to "the city and county of the woman's residence and not the street address". *Wolfe v. Schroering*, 388 F.Supp. 631, 638 (W.D.Ky.1974) *aff'd in part, rev'd in part*, 541 F.2d 523 (6th Cir. 1976). This Court will also adopt that construction since it is logically supported by the legislature's rule that the report is confidential. With this one restraint, therefore, La.Rev.Stat.Ann. § 40:1299.35.10(A) does not infringe on any

108. La.Rev.Stat.Ann. § 40:1299.35.10(A) states:
An individual abortion report for each abortion performed or induced upon a woman shall be completed by her attending physician. The report shall be confidential and shall not contain the name of the woman. This report shall include:
(1) Patient number
(2) Name and address of the abortion facility or hospital
(3) Date of abortion
(4) Zip code or residence of pregnant woman
(5) Age of pregnant woman
(6) Race
(7) Marital status
(8) Number of previous pregnancies
(9) Educational background
(10) Number of living children
(11) Number of previous induced abortions
(12) Date of last induced abortion
(13) Date of last live birth
(14) Method of contraception at time of conception
(15) Date of beginning of last menstrual period
(16) Medical condition of woman at time of abortion
(17) Rh type of pregnant woman
(18) Type of abortion procedure
(19) Complications of type
(20) Type of procedure done after the abortion
(21) Type of family planning recommended
(22) Type of additional counseling given
(23) Signature of attending physician
(24) The certifications provided for in this Chapter.

109. P. Ex. 5, 21.

right of either the doctor or his patient. *But see Doe v. Zimmerman*, 405 F.Supp. 534, 540 (M.D.Pa.1975) (holding unconstitutional the entire section of a statute which required the name and address of the woman who obtained an abortion be kept); *Doe v. Rampton*, 366 F.Supp. 189, 193 (D.Utah 1973) (reporting requirements, including woman's "residence" chilled right of privacy).

B.

Contrary to plaintiffs' assertion,[110] paragraph B of La.Rev.Stat.Ann. § 40:1299.35.-10[111] does not require that all physicians who perform abortions complete complication reports as well as abortion reports. The physician who treats a patient's complications may or may not be the same one who performed the abortion.[112] Although other health care *facilities* may not be required to report similar information, *physicians*, to whom La.Rev.Stat.Ann. § 40:1299.-35.10(B) is addressed, are.[113] The reports will be simple to make and do not reveal the woman's name. Because the reports do not contain any personal information about the woman, it is difficult to see how La. Rev.Stat.Ann. § 40:1299.35.10(B) will have any affect on a woman's decision to have an abortion or her ability to obtain one.

[28] Since La.Rev.Stat.Ann. § 40:1299.-35.10(B) does not infringe on any fundamental right, the Court must analyze the section using the less stringent rationale relationship test. This requirement is not readily distinguishable from other reporting requirements related to the State's interest in health. Reports on complications will provide data on the occurrence of specific risks and help the State to pinpoint those doctors and clinics whose patients are suffering an unusual number of complications.[114] By isolating those doctors who are abusing their professional privileges, the State will be able to take steps to protect its citizens. The Court finds that La.Rev. Stat.Ann. § 40:1299.35.10(B) is rationally related to the State's interest in health and is therefore constitutional.

C.

[29] La.Rev.Stat.Ann. § 40:1299.35.-10(C)[115] requires that doctors sign their abortion and complication reports. This requirement is hardly a burden of constitutional dimensions. La.Rev.Stat.Ann. § 40:1299.35.10(D)[116] requires that the abortion report be made a part of the woman's medical record. This is standard medical procedure. There is no infringement on any privacy interest of the woman because medical records are confidential. There has been no challenge to La.Rev.Stat.Ann.

110. Plaintiffs' Statement of Facts, at 117.

111. La.Rev.Stat.Ann. § 40:1299.35.10(B) states:
An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such post-abortion care. The report shall include:
(1) The date of the abortion.
(2) The name and address of the abortion facility or hospital where the abortion was performed.
(3) The nature of the abortion complication diagnosed or treated.

112. The most common complication, infection, does not become evident until two or three days after the abortion.

113. *See* La.Rev.Stat.Ann. § 40:1093 (West 1977) (births and stillbirths); La.Rev.Stat.Ann. § 40:1065 (West Supp.1979) (venereal disease); La.Rev.Stat.Ann. § 40:1102 (West Supp.1979) (opthalmia neonatorum); La.Rev.Stat.Ann. § 40:1299.1 (West Supp.1979) (sickle cell anemia, phenylketonuria, congenital hypothroidism).

114. *See* Tietze Tr. at 132.

115. La.Rev.Stat.Ann. § 40:1299.35.10(C) states:
All abortion reports shall be signed by the attending physician and submitted to the Department of Health and Human Resources within thirty days after the date of the abortion. All complication reports shall be signed by the physician providing the post-abortion care and submitted to the Department of Health and Human Resources within thirty days after the date of the completion of the post-abortion care.

116. La.Rev.Stat.Ann. § 40:1299.35.10(D) states: "A copy of the abortion report shall be made a part of the medical report of the patient of the facility or hospital in which the abortion was performed."

§ 40:1299.35.10(E)[117] which requires that the Department of Health and Human Resources be responsible for collection of various forms and compilation of an annual report.

EXPERIMENTATION: LA.REV.STAT. ANN. § 40:1299.35.13 (WEST SUPP.1979)[118]

This section states: "No person shall experiment upon or sell a live child or unborn child unless such experimentation is therapeutic to the child or unborn child." La. Rev.Stat.Ann. § 40:1299.35.13 (West Supp. 1979). The plaintiffs have challenged this section as unconstitutionally vague and allege that it burdens the doctors' right to practice medicine or do medical research. The Court finds that these arguments are not supported by the evidence.

Although plaintiffs do not contest the section's prohibition against the sale of live children, they argue that the section's wording will inhibit many legitimate private adoptions in which certain maternity fees may be paid. This fear is ungrounded, however, because La.Rev.Stat.Ann. § 14:286 (B) (West Supp.1979) specifically excludes such maternity fees from its own prohibition against the sale of minor children.

Plaintiffs further contend that the section is so vague that it will inhibit valuable medical experimentation and preclude the use of certain procedures, such as amniocentesis and fetal fluoroscopy. This is a legitimate concern worthy of careful consideration. "[I]ndividual States have broad latitude in experimenting with possible solutions to problems of vital local concern." *Whalen v. Roe*, 429 U.S. 589, 597, 97 S.Ct. 869, 875, 51 L.Ed.2d 64 (1977). This is especially so where matters of social policy, such as health regulations are involved, *Whalen*, 429 U.S. at 597, 97 S.Ct. at 875, and "whether or not [the Court believes it to be] wise. . . ." *Wynn v. Scott*, 449 F.Supp. 1302, 1322 (N.D.Ill.1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979). On the other hand, a criminal statute must be carefully scrutinized where allegations of vagueness have been raised. *Papachristou v. City of Jacksonville*, 405 U.S. 156, 92 S.Ct. 839, 31 L.Ed.2d 110 (1972); *Connally v. General Const. Co.*, 269 U.S. 385, 46 S.Ct. 126, 70 L.Ed. 322 (1926).[119]

This section precludes experimentation which is not "therapeutic." Does this wording sweep so broadly that doctors will be unable to conduct tests or perform operations merely because there is a chance that the patient may be harmed or fail to benefit? The Court finds that this question must be answered in the negative. Therapeutic is defined as "of or relating to the treatment of disease or disorders by remedial agents . . . ." Webster's Third New International Dictionary 2372 (1976) (hereinafter cited Webster's); *see also* Dorland's Illustrated Medical Dictionary 1597 (25th ed. 1974) (hereinafter cited Dorland's). Remedial, in turn, is defined as ". . . *intended* for a remedy or for the removal or abatement of a disease or of an evil . . ." Webster's at 1920 (emphasis added); *see also* Dorland's at 1343. Since experimentation itself involves the chance of failure, the legislature could not have meant that only *successful* experimentation would be therapeutic or it would have said so. The legislature must have meant that it wished to permit only experimentation that is designed to benefit, either in the short or the long term, the individual upon whom it is conducted.[120] Regardless of whether he can

117. La.Rev.Stat.Ann. § 40:1299.35.10(E) states: "The Department of Health and Human Resources shall be responsible for collecting all abortion reports and complication reports and collating and evaluating all data gathered therefrom, and shall annually publish a statistical report based on such data from abortions performed in the previous calendar year."

118. Plaintiffs did not challenge La.Rev.Stat. Ann. § 40:1299.35.11 (Forms) or La.Rev.Stat. Ann. § 40:1299.35.12 (Emergency).

119. *See* n.18, *supra*. *See also*, Note, *The Void-for-Vagueness Doctrine in the Supreme Court*, 109 U.Pa.L.Rev. 67, 88 (1960).

120. *See* 42 C.F.R. § 46.102(a), (b), (c); .201-11 (1979). Whether the State can prohibit all non-

calculate the odds of success, a doctor knows whether an experiment is intended to help a patient. If it is so intended, then it is therapeutic. The Court holds that "therapeutic" is not "so indefinite that the line between innocent and condemned conduct becomes a matter of guesswork." L. Tribe, American Constitutional Law at 718 (1978). Rather, it is possible, by a "reasonable construction of the Statute," *United States v. Harriss*, 347 U.S. 612, 618, 74 S.Ct. 808, 812, 98 L.Ed. 989 (1954), to uphold the constitutionality of La.Rev.Stat.Ann. § 40:1299.35.13.

Plaintiffs have also suggested that this section will burden medical researchers. "[T]he rights of medical researchers are not fundamental under the Constitution . . . .", *Wynn v. Scott*, 449 F.Supp. 1302, 1322 (N.D.Ill.1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979).[121] This is true especially when the experiments involved are to be done on minors[122] and fetuses[123] and are *designed* to be non-therapeutic. The Court notes that this section will not proscribe important medical procedures such as amniocentesis.[124] Amniocentesis is not a therapeutic

therapeutic human experimentation is open to question. Rational adults, capable of informed consent, may wish to participate in experiments or to engage in occupations harmful to their health for many reasons: money, fame, idealism, or, in the case of prisoners, the hope of freedom. *See*, for example, B. A. Franklin, Nuclear Plants Hiring Stand-Ins to Spare Aides Radiation Risks, *N. Y. Times*, July 16, 1979, at A1, Col. 5. The decision in favor of danger may be a thoughtful part of a desire "to shape a life—to plan its pattern and its style—at a higher than ordinary level of risk." TRIBE, at 938. An activity such as being a guinea pig for a dangerous drug can surely be as "expressive" as refusing to wear a motorcycle helmet or demanding the right to have access to saccharin. *Id.* at 940.

121. *But cf.* Comment, *Considerations in the Regulation of Biological Research*, 126 U.Penn. L.Rev. 1420, 1427-35 (1978); Davidson, *First Amendment Protection for Biomedical Research*, 19 Ariz.L.Rev. 893, 899 (1977), "[t]he right to know of and make public scientific advancements and discoveries depends upon the right to do research, just as newsgathering is an activity without which the right to a free press would be ineffectual." (footnote omitted).

122. Note, however, that Louisiana minors can give their consent to treatment, including presumably, experimental methods thereof, under La.Rev.Stat.Ann. § 40:1095 (West 1977).

123. Plaintiffs have made a strenuous attack on the statute on the grounds that it will prevent scientific research which depends on live fetal tissue. However, § 40:1299.35.13 does not prohibit experimentation on fetal tissue, as did the statute in *Wynn v. Scott*, 449 F.Supp. at 1322 ("no exploitation of or experimentation with the aborted tissue"). The Louisiana statute deals with fetuses while they are still *in utero*. *Compare* the instant section with *Wolfe v. Schroering*, 388 F.Supp. 631, 638 (W.D.Ky. 1974) *aff'd in part, rev'd in part*, 541 F.2d 523 (6th Cir. 1976) ("any person who sells or otherwise transfers or permits any form of experimentation on a viable aborted child").

124. Amniocentesis is a procedure in which fluid is withdrawn from the amniotic sac of a pregnant woman. Cells in the fluid, shed by the fetus, can be tested for about sixty hereditary disorders. L. K. Altman, *Birth-Defect Suits Worry Doctors*, *N. Y. Times*, January 30, 1979, § C, at 2, col. 2. It is a technique used increasingly in the field of genetic counseling where fetuses are at risk because of such factors as the mother's age (Down's Syndrome) or family history (Tay-Sachs disease). Without it many women would be less able to determine whether or not to terminate a pregnancy since it may provide the fundamental information they require to make an intelligent decision.

Amniocentesis has become so much a part of medicine that failure to advise a woman that she is at risk, and amniocentesis is available, has been held to constitute malpractice, *Becker v. Schwartz*, 46 N.Y.2d 401, 413 N.Y.S.2d 895, 386 N.E.2d 807 (1978), as has negligent performance of amniocentesis, *Gildner v. Thomas Jefferson U. Hospital*, 451 F.Supp. 692, 696 (E.D.Pa.1978) ("Society has an interest in insuring that genetic testing is properly performed and interpreted") (Tay-Sachs disease). *Compare Berman v. Allan*, 80 N.J. 421, 404 A.2d 8 (1979), and *Karlsons v. Guerinot*, 57 A.D.2d 73, 394 N.Y.S.2d 933 (1977) (upheld action for emotional distress where physician failed to advise at-risk mother of availability of amniocentesis) *with Howard v. Lecher*, 53 A.D.2d 420, 386 N.Y.S.2d 460, *aff'd* 42 N.Y.2d 109, 397 N.Y.S.2d 363, 366 N.E.2d 64 (1977) (dismissing same claims). *See also Park v. Chessin*, 88 Misc.2d 222, 387 N.Y.S.2d 204 (1976), *aff'd* 60 A.D.2d 80, 400 N.Y.S.2d 110 (1977) (failure to warn about possible birth defect).

Amniocentesis is not completely risk-free. While usually safe and accurate, "the needle can damage the fetus or lead to miscarriages or bleeding." *Altman, supra.*

procedure for those fetuses which are defective since discovery of a serious defect will presumably lead to their death *via* abortion. Neither, is it an experiment upon a fetus. It is a *test* [125] as for diabetes or pregnancy or night blindness, rather than an experiment.[126] Doctors do not experiment upon people when they conduct such routine tests. Amniocentesis is used to discover certain inherent defects of a fetus. Physicians recognize the uses of this procedure, its limits, and its risks to both the mother and the fetus. If amniocentesis is not an experiment, La.Rev.Stat.Ann. § 40:1299.35.-13 will be inapplicable. No obstacle has been placed in the path of the woman seeking an abortion or of her doctor. Furthermore, neither doctors nor women seeking abortions need non-therapeutic [127] *in utero* experimentation in order to decide upon or to effectuate an abortion. Therefore, plaintiff's argument that this section intrudes upon a woman's fundamental right of privacy is without merit.

[30] Since this provision does not infringe on a fundamental right, it is subject to the less demanding test of rationality. Statutes regulating human experimentation and *in utero* fetal experimentation are a reasonable exercise of the State's police powers. Given the dangers of abuse inherent in any rapidly developing field, it is rational for a State to act to protect the health and safety of its citizens. The Court notes that several states have joined Louisiana in regulating this area.[128] The Court holds that La.Rev.Stat.Ann. § 40:1299.35.13 is rationally related to the promotion of a legitimate state interest, and La.Rev.Stat. Ann. § 40:1299.35.13 is therefore constitutional.

DISPOSAL OF REMAINS: LA.REV. STAT.ANN. § 40:1299.35.14 (WEST SUPP.1979)

This section [129] provides: "Any physician who shall perform or induce an abortion . . . shall insure that the remains of the unborn child are disposed of in a manner consistent with the disposal of other human remains as provided by [the Human Remains section of the Cemetery Title]." La.Rev.Stat.Ann. § 40:1299.35.14. The Human Remains section requires: "[E]very dead body of a human being lying within this state, and the remains of any dissected body, after dissection, shall be decently interred or cremated within a reasonable time after death." La.Rev.Stat.Ann. § 8:651 (West Supp.1979).[130] The Court recognizes that "the state in the constitutional exercise of its police power may provide for the disposition of dead fetuses to protect the public health." *Planned Parenthood Ass'n.*

125. Test is defined as "an act or process that reveals inherent qualities." Webster's Third New International Dictionary 2361 (1976).

126. Experiment is defined as "a tentative procedure . . . adopted in uncertainty as to whether it will answer the desired purpose or bring about the desired result." Webster's Third New International Dictionary 800 (1976).

127. Whether "therapeutic" is broader or narrower than "to preserve the life or to improve the health of said human embryo or fetus" is not properly before this Court at the present time. *See* La.Rev.Stat.Ann. § 14:87.2 (West 1974) (forbidding most fetal and non-consensual human experimentation).

128. *See* Ill.Ann.Stat. Ch. 38, § 81-32 (Smith-Hurd Supp.1977); Ind.Code Ann. § 35-1-58.5-6 (Burns 1979); S.D. Compiled Laws Ann. § 34-23A-7 (Smith Supp.1976); Utah Crim. Code Ann. § 76-7-310 (Smith 1977). *See also* 45 C.F.R. §§ 46.201-211 (1979).

129. La.Rev.Stat.Ann. § 40:1299.35.14 states: "Any physician who shall perform or induce an abortion upon a pregnant woman shall insure that the remains of the unborn child are disposed of in a manner consistent with the disposal of other human remains as provided by R.S. 8:651 through 8:662."

130. La.Rev.Stat.Ann. § 8:651 (West Supp.1979) requires that all dead bodies be "decently interred or cremated . . . ." Interment is defined as "cremation and inurnment, entombment or burial in a place used or intended to be used, and dedicated, for cemetery purposes." La.Rev.Stat.Ann. § 8:1(26) (West Supp.1979). Cremation is defined as "the reduction of the body of a deceased person to cremated remains in a crematory." La.Rev.Stat.Ann. § 8:1(15) (West Supp.1979). A crematory is any building "with one or more retorts for the reduction of bodies . . . to cremated remains." La. Rev.Stat.Ann. § 8:1(16) (West Supp.1979).

v. Fitzpatrick, 401 F.Supp. 554, 573 (E.D.Pa. 1975), *aff'd sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed.2d 1205 (1976). However, this Court holds that La.Rev.Stat.Ann. § 40:1299.35.14 is an unconstitutional exercise of the State's police power, because it requires that fetal remains be treated with the same dignity as the remains of a person, and thereby, unduly burdens the right of a woman to obtain an abortion.

Roe v. Wade prohibited the State from making a determination as to when life begins, 410 U.S. at 159–62, 93 S.Ct. at 729–31, and held that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." 410 U.S. at 158, 93 S.Ct. at 729. "Since the fetus is not a person," *Poe v. Gerstein*, 517 F.2d 787, 796 (5th Cir. 1975) (citing *Roe*, 410 U.S. at 156–58, 93 S.Ct. at 728–29), neither is it a human being.[131] However, La.Rev.Stat.Ann. § 40:1299.35.14 impermissibly raises the status of a fetus to that of a human being by using language equating fetal remains with human remains: "the remains of the unborn child are disposed of in a manner consistent with the disposal of *other human remains* . . ." (emphasis added). The equation of human and fetal status becomes more pronounced when the section at bar is read in conjunction with the provisions of the Human Remains section, which repeatedly refers to "the dead body of a human being," La.Rev.Stat.Ann. § 8:653 (West Supp.1979), or "the remains of a deceased person," La.Rev.Stat.Ann. § 8:655 (West Supp.1979).

[31] Moreover, the legislative scheme requires that the parents of the fetus select between burial and cremation. La.Rev. Stat.Ann. § 8:655(3) (West Supp.1979). Forcing parents of the fetus to make such a choice is constitutionally impermissible because of the impact upon the pregnant woman's right to obtain an abortion. La. Rev.Stat.Ann. § 40:1299.35.14 incorporates by reference other provisions of La.Rev. Stat.Ann. §§ 8:651 *et seq.* dealing with human remains. Although the mandate of the section at bar is directed to the physician, La.Rev.Stat.Ann. § 8:655 (West Supp. 1979) states:

> The right to control the disposition of the remains of a deceased person, unless other directions have been given by the decedent, vests in and devolves upon the following in the order named:
>
> (1) The surviving spouse, if not judicially separated from the decedent;
>
> (2) The surviving children of the decedent;
>
> (3) *The surviving parents of the decedent;*
>
> (4) The surviving brothers and sisters of the decedent.
>
> (emphasis added).

Thus, reading the section at bar in conjunction with the above quoted statute, the physician performing the abortion would be forced to ask the woman[132] seeking an abortion whether the fetal remains should be buried or cremated. Such a question equates the abortion process with the taking of a human life, because fetal remains are required to undergo the same elaborate formalities of burial or cremation which are traditionally reserved for deceased persons.

131. A person is defined as "an individual human being . . . a human being as distinguishable from an animal or thing . . . ." Webster's Third New International Dictionary 1686 (1976).

132. The Court notes that La.Rev.Stat.Ann. § 8:653(3) (West Supp.1979) presents another issue because it states that the right to dispose of the remains vests in both parents. Seeking the father's direction as to the disposal of fetal remains after the abortion might "invade the privacy of the pregnant woman and burden her decision concerning an abortion." *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F.Supp. 554, 573 (E.D.Pa.1975), *aff'd sub nom., Franklin v. Fitzpatrick*, 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed.2d 1205 (1976), as much as requiring the father to be informed *before* the abortion that the pregnant woman is seeking an abortion. *See Planned Parenthood Ass'n of Cent. Mo. v. Danforth*, 428 U.S. 52, 67–72, 96 S.Ct. 2831, 2840–2842, 49 L.Ed.2d 788 (1976). However, it is unnecessary for this Court to decide this issue because the legislative scheme of La.Rev. Stat.Ann. § 40:1299.35.14 (West Supp.1979) which incorporates La.Rev.Stat.Ann. § 8:653(3) (West Supp.1979) is unconstitutional.

This question concerning funeral arrangements creates the same psychological burden on a pregnant woman feared by plaintiffs in *Planned Parenthood Ass'n. v. Fitzpatrick*, 401 F.Supp. at 573. Thus, the legislative scheme of La.Rev.Stat.Ann. § 40:1299.35.14 would have a chilling affect on a woman's right to obtain an abortion and represents an impermissible attempt of the State to influence a woman's abortion decision.

LICENSING: LA.REV.STAT.ANN. §§ 40:1299.35.16, .17 (WEST SUPP.1979) [133]

La.Rev.Stat.Ann. § 40:1299.16 of the Act requires that all abortion facilities shall be licensed by the Louisiana Department of Health and Human Resources. La.Rev. Stat.Ann. § 40:1299.35.17 sets forth detailed standards for licensing, requiring that each abortion facility have specified drugs and equipment on hand. Further, the licensing standards section requires that all abortion facilities shall provide emergency transportation capable of transporting patients to hospital emergency rooms within fifteen minutes. The requirements imposed by these sections apply to all abortion facilities and all abortion procedures, without regard to the trimester of pregnancy when the abortion is performed. The Court holds that these two sections are unconstitutional because they are an attempt by the State to regulate abortion procedures before the State's interest in maternal health becomes compelling.

In considering the sections at bar, the Court is guided by the following language from *Roe v. Wade*:

133. La.Rev.Stat.Ann. § 40:1299.35.16 states:

All abortion facilities shall be licensed by the Department of Health and Human Resources before commencing operation. The license shall be renewable annually, and shall be granted or renewed only after certification that the facility has met the following standards as well as complied with the provisions enumerated in R.S. 40:1299.35.1 through 40:1299.35.15 above.

La.Rev.Stat.Ann. § 40:1299.35.17 states:

An annual fee of one thousand dollars shall be paid by each abortion facility applying for licensure under the provisions R.S. 40:1299.-35.1 through 40:1299.35.18. An additional fee of five hundred dollars shall be paid for each physician employed in performing or inducing abortions at an abortion facility.

B. All facilities, equipment and supplies shall be maintained in proper working order. Necessary solutions, drugs, and medications shall be supplied and maintained. All equipment shall be maintained in a clean and sanitary condition.

C. There shall be available on the premises an emergency transportation service or arrangements with a private ambulance service insuring that a patient requiring emergency care at a hospital will be transported to such hospital within fifteen minutes from the time of diagnosis at the abortion facility of a complication requiring emergency care at a hospital.

D. There shall be on the premises a clinical laboratory certified to perform urinalysis, hematocrit, and other hematological tests, including cross matching and determination of blood and Rh type.

E. There shall be on the premises a standard operating room, capable of accommodating abdominal as well as vaginal surgical procedures, or a written agreement with a hospital located within fifteen minutes total transport time for the use of a standard operating room in the treatment of its patients requiring such surgical procedure.

F. All rooms in which abortions are performed shall be adequately equipped, supplied and staffed and shall include the following in addition to the instruments and equipment needed for the performance of abortions or other comparable surgical procedures:

1. Anesthesia equipment and such other equipment as is necessary to treat patients for hemorrhage, shock, cardiac arrest, and other emergencies.

2. An adequate supply of drugs, plasma expanders, and parenteral fluids with appropriate refrigerant equipment therefor.

3. Available Rho (L) immune globulin for use when indicated, or the procedure to prevent Rh sensitization.

4. Dressing rooms and scrub-up facilities suitably located.

G. There shall be an adequately sized separate recovery room or rooms in proximity to the operating facilities and containing adequate monitoring equipment, suction, oxygen, and other related equipment for resuscitation, including a defibrilator, and staffed by a registered professional nurse.

H. At least one registered nurse shall be on duty at all times while the facility is in use.

I. There shall be a receiving facility where the patient may be prepared and receive necessary preoperative medication and observation prior to surgery.

> With respect to the State's important and legitimate interest in the health of the mother, *the "compelling" point*, in the light of present medical knowledge, *is at approximately the end of the first trimester.* . . . It follows that, *from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health.* Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like. This means, on the other hand, that, *for the period of pregnancy prior to this "compelling" point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.* *Roe*, 410 U.S. at 163, 93 S.Ct. at 731–32 (emphasis added).

This language demonstrates that only after the first trimester may a state enact regulations reasonably related to the protection of maternal health. In a decision reviewing licensing requirements, the Seventh Circuit Court of Appeal held that regulations similar to the instant sections were unconstitutional. Commenting on the meaning of the *Roe v. Wade* quotation cited above, the Seventh Circuit concluded:

> If there was any doubt as to whether the Supreme Court was declaring broad health and safety regulations for first trimester abortions impermissible, it was cleared up by the Court's description of what became permissible *after* that period. It was only after the "compelling point" that the Court said permissible state regulations could include requirements as to the specialty qualifications of the person who is to perform the abortion, the type of facility where it might be performed and similar types of regulations.
>
> *Friendship Medical Cen., Ltd. v. Chicago Bd. of Health*, 505 F.2d 1141, 1150 (7th Cir. 1974) (footnote omitted).

[32] Further precedent supporting the decision of this Court may be gleaned from the Supreme Court's holding in *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201 (1973). In *Doe*, the Supreme Court reviewed Georgia legislation setting forth licensing standards for abortion facilities and physicians. The licensing standards applied to all abortion procedures, without regard to the trimester of pregnancy when the abortion was performed. The Supreme Court held that these requirements were unconstitutional and then stated: "This is not to say that Georgia may not or should not, from and after the end of the first trimester, adopt standards for licensing all facilities where abortions may be performed so long as those standards are legitimately related to the objective the State seeks to accomplish." *Doe*, 410 U.S. at 194–95, 93 S.Ct. at 749. This Court therefore holds that the regulations imposed by La.Rev. Stat.Ann. §§ 40:1299.35.16, .17 are clearly unconstitutional because they impose restrictions upon a woman's right to obtain an abortion prior to the period when the State's interest in maternal health becomes compelling.

ESTABLISHMENT OF RELIGION

[33] Plaintiffs' final argument attacks the entire Act as an establishment of religion in violation of the First Amendment of the Constitution. The Court finds that this argument has no merit. The Act satisfies the three prong test laid down in *Committee for Pub. Educ. & Religious Liberty v. Nyquist*, 413 U.S. 756, 773, 93 S.Ct. 2955, 2965, 37 L.Ed.2d 948 (1973). First, there is a clearly secular legislative purpose: health regulation for the protection of citizens undergoing a particular medical procedure. Second, the Act's primary effect neither

advances nor inhibits religion. As presently constituted, the Act no longer contains the language to which plaintiffs objected. *Plaintiffs' Memorandum of Law*, at 89–90. Third, the Act does not involve excessive entanglement with religion. Political fragmentation over abortion splinters individual families as well as religions, political parties, and church groups. The Act does not outlaw abortion; it merely attempts to regulate it, which is a valid exercise of the State's police powers. The Court therefore concludes that the Act as a whole does not violate the First Amendment.

For reasons previously stated, certain provisions of the Act [134] have been held to be unconstitutional, and therefore, the Court will enter an order striking the following sections:

1. La.Rev.Stat.Ann. § 40:1299.35.3
2. La.Rev.Stat.Ann. § 40:1299.35.4
3. La.Rev.Stat.Ann. § 40:1299.35.5
4. La.Rev.Stat.Ann. § 40:1299.35.6(A) insofar as it requires consent of a minor's parent or guardian
5. La.Rev.Stat.Ann. § 40:1299.35.6(B) insofar as it requires consent of a minor's parent or guardian
6. La.Rev.Stat.Ann. § 40:1299.35.6(B)(3)–(6)
7. La.Rev.Stat.Ann. § 40:1299.35.6(C) insofar as it requires consent of a minor's parent or guardian
8. La.Rev.Stat.Ann. § 40:1299.35.6(D) insofar as it requires consent of a minor's parent or guardian
9. La.Rev.Stat.Ann. § 40:1299.35.7
10. La.Rev.Stat.Ann. § 40:1299.35.8
11. La.Rev.Stat.Ann. § 40:1299.35.9
12. La.Rev.Stat.Ann. § 40:1299.35.10(A)(4) insofar as it requires the doctor to list a woman's residence
13. La.Rev.Stat.Ann. § 40:1299.35.14
14. La.Rev.Stat.Ann. § 40:1299.35.16
15. La.Rev.Stat.Ann. § 40:1299.35.17

Injunctive relief is denied, as the Court assumes that Louisiana authorities will give credence to this decision. *Wooley v. Maynard*, 430 U.S. 705, 711–13, 97 S.Ct. 1428, 1433–34, 51 L.Ed.2d 752 (1977); *Planned Parenthood Ass'n. v. Fitzpatrick*, 401 F.Supp. 554, 582–83 (E.D.Pa.1975), *aff'd sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed.2d 1205 (1976); *Hodgson v. Anderson*, 378 F.Supp. 1008, 1019 (D.Minn.1974), *aff'd in part, rev'd in part and remanded*, 542 F.2d 1350 (8th Cir. 1976).[135]

So ordered.

ORDER

Pursuant to the opinion of the Court rendered this the 29th day of February, 1980;

IT IS HEREBY ORDERED, ADJUDGED, and DECREED that the following sections of the Louisiana abortion statute, La.Rev.Stat.Ann. §§ 40:1299.35.1 *et seq.* (West Supp.1979), are hereby stricken as unconstitutional enactments:

1. La.Rev.Stat.Ann. § 40:1299.35.3
2. La.Rev.Stat.Ann. § 40:1299.35.4
3. La.Rev.Stat.Ann. § 40:1299.35.5
4. La.Rev.Stat.Ann. § 40:1299.35.6(A) insofar as it requires consent of a minor's parent or guardian
5. La.Rev.Stat.Ann. § 40:1299.35.6(B) insofar as it requires consent of a minor's parent or guardian
6. La.Rev.Stat.Ann. § 40:1299.35.6(B)(3)–(6)

134. Certain sections of the Act are not reported in the present West pocket part. They are the last two paragraphs of the act.

Section 2. If any provision or item of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions, items, or applications of this Act which can be given effect without the invalid provisions, items, or applications, and to this end the provisions of this Act are hereby declared severable.

Section 3. All laws or parts of laws in conflict herewith are hereby repealed.
1978 La.Sess.La.Serv.No. 435, §§ 2, 3 (West 1978).

135. "[A] Court should enter only a declaratory judgment, and not the injunctive relief requested, if [it is] satisfied that defendants will acquiesce in the decision holding the challenged provisions of the Act unconstitutional." *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F.Supp. at 582, and cases cited therein.

7. La.Rev.Stat.Ann. § 40:1299.35.6(C) insofar as it requires consent of a minor's parent or guardian

8. La.Rev.Stat.Ann. § 40:1299.35.6(D) insofar as it requires consent of a minor's parent or guardian

9. La.Rev.Stat.Ann. § 40:1299.35.7

10. La.Rev.Stat.Ann. § 40:1299.35.8

11. La.Rev.Stat.Ann. § 40:1299.35.9

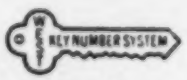
12. La.Rev.Stat.Ann. § 40:1299.35.10 (A)(4) insofar as it requires the doctor to list a woman's residence

13. La.Rev.Stat.Ann. § 40:1299.35.14

14. La.Rev.Stat.Ann. § 40:1299.35.16

15. La.Rev.Stat.Ann. § 40:1299.35.17;

IT IS FURTHER ORDERED, ADJUDGED, and DECREED that injunctive relief is denied, as the Court assumes that Louisiana authorities will give credence to this decision. *Wooley v. Maynard*, 430 U.S. 705, 711–13, 97 S.Ct. 1428, 1433–34, 51 L.Ed.2d 752 (1977); *Planned Parenthood Ass'n. v. Fitzpatrick*, 401 F.Supp. 554, 582–83 (E.D.Pa.1975), *aff'd sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed.2d 1205 (1976); *Hodgson v. Anderson*, 378 F.Supp. 1008, 1019 (D.Minn.1974), *aff'd in part, rev'd in part and remanded*, 542 F.2d 1350 (8th Cir. 1976).



Document #19

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

DR. RICHARD F. MUCIE,

Petitioner,

v.

EWING COURLEY, Director, Division of Corrections, Missouri Department of Social Services,[1]

W. R. VERMILLION, Chairman, and DICK D. MOORE and FERD N. STURM, Members, Missouri Board of Probation and Parole, and

EDITH C. WESTLEY, Chief Criminal Clerk, Circuit Court of Jackson County, Missouri,[2]

Respondents.

Civil Action
No. 73CV497-W-3

FINAL JUDGMENT GRANTING PETITION
FOR A WRIT OF HABEAS CORPUS

This is a petition for a writ of habeas corpus under Section 2254, Title 28, United States Code. Petitioner, a physician, seeks release from the custody of the Missouri Board of Probation and Parole and expungement of his criminal record on the grounds that his 1968 conviction for manslaughter in the commission of an abortion under Section 559.100, R.S.Mo. (1969), V.A.M.S.[3] was retroactively invalidated by the United States Supreme Court decision in Roe v. Wade, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973) and Doe v. Bolton, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201 (1973), and the three-judge court decision in Rodgers v. Danforth, Civil Action No. 18360-2 (W.D.Mo. May 18, 1973).

Attest True Copy
R. F. Connor, Clerk
U. S. District Court
By [signature]
Deputy

A determination of the merits of the petition was initially stayed pending exhaustion of state remedies under Missouri Supreme Court Rule 27.26.[4] Thereafter, petitioner filed a motion to vacate sentence under Missouri Supreme Court Rule 27.26 in the Circuit Court of Jackson County, Missouri. After over two years elapsed without a determination of the merits of the 27.26 motion by the Circuit Court of Jackson County, Missouri, petitioner renewed his request for a determination of the merits of the petition on the grounds that his state remedy was inadequate. Petitioner's request was denied without prejudice to renewal after pursuit of his state appellate remedies from the denial of his 27.26 motion.[5] However, the Eighth Circuit Court of Appeals ruled that state court delay had rendered petitioner's state remedies inadequate, and remanded the petition for a hearing on the merits. Mucie v. Missouri State Department of Corrections, 543 F.2d 633 (8th Cir. 1976).[6] A plenary evidentiary hearing was held on May 13, 1977.

For the reasons stated below, the petition will be granted.

I. Findings of Fact.

On February 13, 1968, the Grand Jury of the Circuit Court of Jackson County, Missouri returned an indictment charging petitioner with manslaughter in the death of one Nancy Ward on February 8, 1968, during the commission of an abortion, in violation of Section 559.100, R.S.Mo. (1969) V.A.M.S. On June

8, 1968, petitioner was convicted by a jury and sentenced to a term of ten years imprisonment.[7] The conviction and sentence were affirmed on appeal by the Missouri Supreme Court. State of Missouri v. Mucie, 448 S.W.2d 879 (Mo. 1970). A petition for a writ of certiorari was denied by the United States Supreme Court. Mucio v. Missouri, 398 U.S. 938, 90 S.Ct. 1842, 26 L.Ed.2d 271 (1970).

The following facts regarding the offense for which petitioner was convicted are found on the basis of the evidence adduced at petitioner's trial and at the hearing on the petition.

The victim, Nancy Ward, was a nineteen year old student at the University of Oklahoma from Las Vegas, Nevada. In late November, 1967, she advised her boy friend that she was pregnant and had decided to seek an abortion because she was not ready for marriage and did not wish to keep the baby. Her boy friend, who was from Kansas City, Missouri, sought the assistance of his father in obtaining an abortion.

On January 30, 1968, the boy friend's father contacted petitioner in Kansas City, Missouri, and sought his assistance in terminating the pregnancy. Petitioner requested the father to have the girl examined by a doctor to determine the stage of the pregnancy. From his son, the father learned that the onset of pregnancy was the first or middle of October, 1967, and upon relaying this information to petitioner, was told that "it was too late to do anything about it." After the father relayed

this advice to his son, the father was told that the girl had not been examined. The father again told his son to have the girl examined, and, subsequently, was told that the girl was thirteen to fourteen weeks pregnant. This information was relayed to petitioner who advised the son's father to have the girl come to Kansas City on the evening of February 7, 1968.

On February 7, 1968, the victim and her boy friend flew to Kansas City, arriving at 6:30 p.m. They went directly to meet petitioner at his Kansas City Sinus Clinic at 1924 East 31st, Kansas City, Missouri. Petitioner examined the girl for approximately fifteen minutes. He told them that he couldn't do anything at the time, but that he would telephone them at their hotel about 11:30 p.m. and then drive them back to the Sinus Clinic.

At 11:00 p.m., petitioner telephoned the couple, and approximately forty minutes later arrived at the hotel to return them to the Sinus Clinic. Petitioner took the girl to the inner office while the boy waited in the outer office. In twenty to thirty minutes, petitioner returned to the outer office and asked the boy if he would like to pay him before he started. The boy paid him $400 at that time.

The circumstantial evidence presented at the trial indicates that petitioner attempted an abortion by the dilation and curettement method, which involves stretching of the womb opening and then scraping of the inside of the womb with a curette, a spoon shaped instrument with a hole in the bottom and one sharpened edge. In

the course of this procedure, the wall of the uterus was perforated by a tear one-half inch in length, one-half inch in thickness, and one-thirty second inch maximum width. Hemorrhage from the tear sent the girl into shock. Although petitioner attempted to revive the girl through emergency and resuscitory measures, she died at approximately 9:00 a.m. while still at the Sinus Clinic, and prior to being taken to Osteopathic Hospital at approximately 11:30 a.m. The cause of death was determined to be shock resulting from the hemorrhaging uterus. An autopsy disclosed parts of a fetus in the girl's womb which, by size, was estimated to have reached four and one-half to five months gestation.

A material factual issue is whether the abortion performed by petitioner was performed in such a manner or under such conditions that in the interest of protecting the health of the mother, the State could have prohibited it. At the hearing, petitioner presented uncontroverted expert testimony by Dr. Robert D. Crist, Associate Professor of Obstetrics and Gynecology at Kansas University Medical School, that the fifteen minute examination and consultation with the victim prior to the abortion was sufficient to obtain an adequate medical history and psychological evaluation; that the dilation and curettement procedure used was the primary abortion technique used in 1968 and was statistically safer than other abortion techniques such as a hysterotomy; that perforation of the uterine wall is a recognized risk in use of the dilation

and curettement procedure and does not alone indicate carelessness or negligence; and finally, that the performance of such abortions in a clinical setting rather than in a hospital is medically acceptable. On the basis of this uncontroverted testimony by a qualified expert witness, it is found that the abortion in this case was performed in such a manner and under such conditions that it could not have been prohibited by the State in the interest of protecting the life of the mother.

It should be noted that at the time of petitioner's prosecution, the conduct with which petitioner was charged was a clear violation of Section 559.100, R.S.Mo. (1969) V.A.M.S. There is no evidence that the prosecution was in any respect discriminatory or in bad faith. Rather, the evidence shows that those involved in petitioner's prosecution acted in good faith under the law as it then existed. In fact, a failure to prosecute petitioner under the law as it then existed would have been a dereliction of duty.

II. Conclusions of Law.

On January 22, 1973, the United States Supreme Court ruled that the Texas abortion statute, which, like Section 559.100, R.S.Mo. (1969) V.A.M.S., prohibited all abortions unless necessary to save the life of the mother or the unborn child, unconstitutionally infringed the privacy right of the mother to decide whether or not to terminate her pregnancy. Roe v. Wade, supra; Doe v. Bolton, supra. The Court expressly held "that the Texas abortion statutes, as

a unit, must fall." Roe v. Wade, supra., 410 U.S. at 166, 35 L.Ed.2d at 184. On May 18, 1973, a three-judge court declared Section 559.100, R.S.Mo. unconstitutional on the basis of Roe v. Wade, supra., and Doe v. Bolton, supra.

Petitioner's conviction became "final" on June 1, 1970, when the United States Supreme Court denied his petition for a writ of certiorari. Linkletter v. Walker, 381 U.S. 618, 622 n. 5, 85 S.Ct. 1731, 14 L.Ed.2d 601, 604 (1965). Therefore, it is necessary to determine whether Roe v. Wade, supra, Doe v. Bolton, supra, and Rodgers v. Danforth, supra, are to be given retroactive application, and if so, whether those decisions accord constitutional protection to the conduct of petitioner.

In an order filed December 22, 1976, a copy of which is attached as Appendix A, it was concluded that Roe v. Wade, supra., Doe v. Bolton, supra., and Rodgers v. Danforth, supra. are to be given retroactive application. However, it was further concluded that retroactive application of those decisions does not automatically invalidate all abortion convictions which became final prior to the dates Roe, Doe, and Rodgers were decided. Because the right of privacy which was held to include the abortion decision "is not unqualified and must be considered against important state interests in regulation," Roe v. Wade, supra., 410 U.S. at 154, 35 L.Ed.2d at 177-178, a determination must be made whether the abortion was performed in a manner or under conditions which could be constitutionally regulated

by the State. See Connecticut v. Menillo, 423 U.S. 9, 96 S.Ct. 170, 46 L.Ed.2d 152 (1975).

The expert medical testimony at petitioner's trial established that the victim was four and one-half to five months pregnant at the time of the abortion. In Roe v. Wade, supra., the Supreme Court ruled that during the second trimester of pregnancy,

> " ... the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health." Id., 410 U.S. at 165, 35 L.Ed.2d at 183.

The Court gave as examples of permissible regulation after the first trimester

> " ... requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like. Id., 410 U.S. at 163, 35 L.Ed.2d at 182-183.

As factually found above on the basis of the evidence presented at the hearing, the abortion performed by petitioner was performed by a licensed physician in a medically accepted manner under medically accepted conditions. Therefore, the State cannot validly justify prohibiting of the abortion in terms of its interest in maternal health. Because it is concluded that petitioner's conduct was constitutionally protected under Roe v. Wade, supra., Doe v. Bolton, supra., and Rodgers v. Danforth, supra., the petition for a writ of habeas corpus will be granted.

For the foregoing reasons, it is therefore

ORDERED and ADJUDGED that respondents Ewing Gourley, W. R. Vermillion, Dick D. Moore, and Ferd N. Sturm be, and they are hereby, directed to release petitioner from all further custody of the Missouri Board of Probation and Parole forthwith.

It is further

ORDERED and ADJUDGED that respondent Edith C. Westley be, and she is hereby, directed to expunge all record of petitioner's conviction for violation of Section 559.100, R.S.Mo. (1969) V.A.M.S., on June 8, 1968.

William H. Becker
Senior Judge

Kansas City, Missouri
Date: 7-27-77

NOTES

1. The successor in office to the Director of the Division of Corrections named in the original petition has been substituted under Rule 25(d), F.R. Civ. P.

2. The State Board of Registration for the Healing Arts, named as respondent in the original petition, has been dropped as a respondent because petitioner's license to practice medicine has been restored.

3. Section 559.100, R.S.Mo. (1969) V.A.M.S. provides:

> Any person who, with intent to produce or promote a miscarriage or abortion, advises, gives, sells or administers to a woman(whether actually pregnant or not), or who, with such intent, procures or causes her to take, any drug, medicine or article, or uses upon her, or advises to or for her the use of, any instrument or other method or device to produce a miscarriage or abortion (unless the same is necessary to preserve her life or that of an unborn child, or if such person is not a duly licensed physician, unless the said act has been advised by a duly licensed physician to be necessary for such a purpose), shall, in the event of the death of said woman, or any quick child, whereof she may be pregnant, being thereby occasioned, upon conviction be adjudged guilty of manslaughter, and punished accordingly; ... and any practitioner of medicine or surgery, upon conviction of any such offense, as is above defined, shall be subject to have his license or authority to practice his profession as physician or surgeon in the state of Missouri revoked by the state board of medical examiners in its discretion.

4. Mucie v. Missouri Department of Corrections, Civil Action No. 73CV497-W-3 (W.D.Mo. October 26, 1973).

5. Mucie v. Missouri Department of Corrections, Civil Action No. 73CV497-W-3 (W.D.Mo. April 5, 1976).

6. Despite the remand for a determination on the merits by the Eighth Circuit Court of Appeals, petitioner has continued to pursue his state appellate remedies from the denial of his 27.26 motion in the Missouri Court of Appeals, Kansas City District. Mucie v. State, No. 28618 (Mo.App. K.C.D.). The appeal was orally argued on May 12, 1977. No decision has been filed to date.

7. Petitioner was released on parole on March 30, 1971, after service of fourteen months in the Missouri Department of Corrections.

Motion to Dismiss or Affirm

Office - Supreme Court, U.S.
FILED
NOV 2 1981
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

Record No. 81-185

CHRIS SIMOPOULOS, M.D., FACOG,
Appellant,

v.

COMMONWEALTH OF VIRGINIA,
Appellee.

On Appeal From The Supreme Court of Virginia

MOTION TO DISMISS
MOTION TO AFFIRM

MARSHALL COLEMAN
Attorney General of Virginia

THOMAS D. BAGWELL
Assistant Attorney General

Supreme Court Building
1101 East Broad Street
Richmond, Virginia 23219
(804) 786-2071)

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IN THE

OCTOBER TERM, 1980

Supreme Court of the United States

Record No. 81-185

CHRIS SIMOPOULOS, M.D., FACOG,

Appellant,

v.

COMMONWEALTH OF VIRGINIA,

Appellee.

MOTION TO DISMISS
MOTION TO AFFIRM

PRELIMINARY STATEMENT

The Appellee, Commonwealth of Virginia, respectfully moves to dismiss the appeal and affirm the judgment of the Supreme Court of Virginia entered on April 24, 1981.

OPINION BELOW

The judgment of the Supreme Court of Virginia is a published opinion reported as *Commonwealth v. Simopoulos,* 221

Va. 1059, 277 S.E.2d 194 (1981). A copy of the opinion is reproduced in the Jurisdictional Statement of the Appellant at 1.a through 21.a. The final order of the Supreme Court on the appeal was entered on April 24, 1981. A copy of that order is found in the Jurisdictional Statement of the Appellant at page 31a.

JURISDICTION

The Appellant asserts that the jurisdiction of this Court is grounded upon 28 U.S.C. § 1257(2), (3). The statutes involved are found in footnote 2 of the Opinion of the Virginia Supreme Court found at pages 4a through 6a of the Appellant's Jurisdictional Statement.

QUESTIONS PRESENTED

1. DID THE SUPREME COURT ERR IN FINDING THAT THE BURDEN OF PROOF DID NOT REST ON THE APPELLANT TO ESTABLISH MEDICAL NECESSITY FOR THE ABORTION IN VIOLATION OF THE DUE PROCESS CLAUSE?
2. DOES THIS COURT HAVE JURISDICTION TO REVIEW SUFFICIENCY OF EVIDENCE ON AN APPEAL?
3. WAS THE EVIDENCE SUFFICIENT TO PROVE CAUSATION?
4. DID THE MANDATORY HOSPITALIZATION REQUIREMENT RESTRICT ACCESS TO SECOND TRIMESTER ABORTIONS BY DELEGATING AUTHORITY TO HOSPITALS TO BAN SUCH ABORTIONS?
5. DID THE MANDATORY HOSPITAL REQUIREMENT VIOLATE THE APPELLANT'S RIGHT TO DUE PROCESS BY REQUIRING PARENTAL CONSENT?

STATEMENT OF THE CASE[1]

On Thursday, November 8, 1979, Patricia Anne McDonald travelled from her home in Woodbridge to the American Women's Clinic at 916 West Broad Street, in the City of Falls Church. Her purpose was to procure an abortion for herself. (App. 316). She had decided upon that clinic, the establishment of Appellant, after telephoning several other clinics. At no point did she call any hospitals. (App. 331).

During that visit the Appellant was told by the girl that she believed herself to be five and one-half months pregnant. (App. 319). The Appellant, after examining her, concurred and made a notation in her file consisting of "pregnancy, five months . . . . scheduled for saline injection." (App.298).

Two days later, on Saturday, November 10, 1979, Patricia McDonald returned to the American Women's Clinic for her 11:00 a.m. appointment. (App. 320). The Appellant told her that because of the injection, the fetus would be destroyed. (App. 343). The Appellant then performed the saline amniocentesis procedure, whereby he injected a salt solution through the stomach of the girl and into the amniotic sac surrounding the unborn child. (App. 320). He stated that he did this with the expectation that the pregnancy would abort. (App. 461). He then prescribed percodan for stomach pains.

Following the injection, the Appellant informed the girl that, despite the 'follow-up instructions' given her by the receptionist, there was no requirement that she go to a hospital at any time. (App. 319, 453). The Appellant was aware that she was not going to a hospital. (App. 448, 482). He admitted that his printed "instructions" contained no mention of Fairfax Hospital, the only hospital in Northern Virginia permitting second trimester abortions at which the Appellant had privileges. (App. 432).

Patricia McDonald then had the prescription for percodan filled, and proceeded to the Springfield Howard Johnson Motel

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[1] References to the record of trial are found in the Appendix in the Virginia Supreme Court.

where she spent the ensuing 40 hours. She began experiencing labor contractions at about midnight, Sunday, and delivered the body and placenta in the bathroom. (App. 325). She departed at about noon on Monday. (App. 344).

Investigator James R. Dooley, Jr. responded to a call that a dead child had been found in a motel trash basket. (App. 243). A prescription bottle was also discovered in the basket, too, and Investigator Dooley found it to bear the names of both Patricia McDonald and Chris Simopoulos. (App. 250). Not knowing if the prescription was legitimate or what relation, if any, it had with the dead fetus, Investigator Dooley telephoned the Appellant. (App. 252). Since the Appellant was engaged with a patient, he was unable to speak with the investigator immediately. He did, however, return the call soon after. During the conversation that followed, the Appellant confirmed the fact that he had prescribed percodan for Patricia McDonald (App. 252) in connection with the abortion he had recently performed upon her. (App. 253). At this time, Investigator Dooley was still not aware that a crime had been committed. (App. 261). Over the period of the next two weeks, Investigator Dooley's investigation revealed that there had been a violation of Virginia Code § 18.2-71, and the Appellant was subsequently arrested pursuant thereto on November 29, 1979.

ARGUMENT

THE APPELLANT DID NOT BEAR THE BURDEN OF PROOF THAT THE ABORTION WAS FOR MEDICAL NECESSITY.

The petitioner has alleged that because the indictment fails to negate the abortion was necessary to save the woman's life that the burden of proof has been shifted to the Appellant both by the indictment and the evidence. This he says violates his due process right to the presumption of innocence, and also his Fifth Amendment privilege against self-incrimination. The chief case which the Appellant has cited in support of his position is *United States* v. *Vuitch,* 402 U.S. 62, 71 (1971), where the Supreme Court held that it was the prosecution's burden to

plead and prove that the abortion was not necessary for the preservation of the mother's life. 402 U.S. at 71. The Commonwealth does not agree that the indictment must negate that exception in the indictment, nor must the Commonwealth prove that the abortion was not necessary to save the woman's life unless the Appellant makes some assertion that the abortion was necessary to save the woman's life.

Vuitch is distinguishable from the case at bar. The statute in question in *Vuitch* had the exception incorporated into the enacting clause of the statute, and thus the court reasoned that the burden is on the prosecution to plead and prove that the Appellant is not within the exception. 402 U.S. at 70. In our statutes the exception is not within the enacting clause of the statute but is within a separate action. *See* § 18.2 -74.1. The Commonwealth concedes that once asserted the burden is on the Commonwealth to negate this exception. Procedurally, however, the Commonwealth argues that the indictment need not negate this exception. In this regard, the Court in *People* v. *Bricker,* 201 N.W.2d 647 (Mich. App. 1972) found that even though the statute which stated the prosecution was not required to negate such an exception was unconstitutional, the Court went further and found that the prosecution had in fact carried its burden in this particular regard. The Virginia Supreme Court found that the Commonwealth met its burden. The Appellant's notes describing the patient's condition as "normal" refuted Appellant's claim of medical necessity.

It should be further noted that it is certainly arguable that the exception as set forth in § 18.2-74.1 is negated by the words "unlawfully" and "feloniously" as written in the indictment. This is what the Court found in *Commonwealth* v. *Brunelle,* 171 N.E.2d 850 at 852 (Mass. 1960).

In order for the Commonwealth to be required to negate the defense that the abortion was necessary for the health of the woman, the Appellant must first assert this as a defense. The Appellant did not generate any defense or even make an assertion that the operation was necessary to preserve the health of

the woman. It cannot be seriously argued that the abortion was done to save her life; Appellant had ample time to hospitalize the prosecutrix. Appellant sent her home on one day, performed the injection thereafter, and not once made any attempt to admit her to a hospital. *Cf. Wynn v. Scott,* 449 F.Supp. 1302, 1318 (N.D. Ill. 1979); *aff'd,* 599 F.2d 193 (7th Cir.), *appeal dismissed for lack of jurisdiction,* 439 U.S. 8 (1979).

The evidence proves that the abortion was not in any sense performed to preserve the health of the prosecuting witness, Patricia McDonald. Her testimony indicates that she went to the clinic for the purpose of an abortion and she obtained an abortion; she was not depressed when she first went to the clinic nor upset about the pregnancy. (App. 331-332). There is no evidence that the abortion was necessary to preserve the physical health of the witness. In any event, the Commonwealth argues that evidence clearly negated any assertion by the defendant of medical necessity.

The Virginia Supreme Court in its opinion found that the distinction exists in the Virginia statutory framework that did not exist in *United States v. Vuitch,* 402 U.S. 62 (1971) as alleged by the Appellant. Furthermore, the Court found that the Commonwealth proved that the abortion was not performed because of any medical necessity.

THE ISSUE OF CAUSATION IS NOT PROPERLY BEFORE THIS COURT.

The Commonwealth moves to dismiss this question because it is not properly before this Court. This allegation deals solely with sufficiency of the evidence which should be presented to this Court in a petition for a writ of certiorari. The time limit for such a petition has expired, and the Appellant did not file his jurisdictional statement within the time required in order for this issue to be considered as if presented in a petition for a writ of certiorari.

THE EVIDENCE WAS SUFFICIENT TO PROVE CAUSATION.

The Appellant has argued that the Commonwealth has not alleged or proven that any act he committed caused the abortion. The Commonwealth submits that, after examining the Commonwealth's evidence, it is clear that the evidence was sufficient to show that the defendant caused the abortion. Patricia McDonald went to the defendant specifically for an abortion and advised him that she was twenty-two weeks pregnant. (App. 316, 319). The Appellant injected her with a saline solution on Saturday, and she delivered on Monday. (App. 320-325). The medical evidence revealed that the fetus was born dead, and that it was five and one-half months old. (App. 273, 275). The Appellant's records show that the prosecutrix was injected by the Appellant with a saline injection. The Appellant's notes indicate that the procedure was performed without complications. (App. 299). The Appellant admitted that the injection was for the purpose of an abortion and that the procedure went well (App. 461). The Appellant testified that if the procedure is performed correctly that the fetus would be destroyed. (App. 464). Doctor Soyster testified that the likelihood of a saline amniocentesis resulting in fetal death is 85 to 95 per cent. (App. 293). The Commonwealth argues, therefore, that where the prosecuting witness testifies that she went specifically to the Appellant for a second trimester abortion and that saline amniocentesis was performed on her with the express intent to produce an abortion, and this same witness had a miscarriage within the time that this procedure normally produces such a miscarriage, that causation has been proven beyond a reasonable doubt.

The Virginia Supreme Court found that the Commonwealth need not prove that the actual instillation of the saline caused the death of the fetus. All the Commonwealth had to prove was that "that the saline injection caused *either* the death of the fetus *or* the expulsion of the fetus." Viewing the evidence as a

whole and all the inferences to be drawn therefrom favorable to the Commonwealth, it is reasonable to infer that the saline injection caused the destruction of the fetus.

HOSPITALIZATION REQUIREMENT.

The mandatory hospitalization requirement does not unduly restrict access to second-trimester abortions, nor does it delegate to the hospitals the authority to ban such abortions.

With respect to the Appellant's arguments concerning access to the hospitals, there were two hospitals in Northern Virginia and 24 hospitals located elsewhere in the State providing abortion services. To the extent access to hospital abortion services was inconvenient or conditioned upon parental consent, the limitations were not obstacles created by the State. Where a private hospital is allowed to place restrictions on abortions under § 18.2-75, Code of Virginia (1950), as amended, it does not require them to do so nor is it required to forbid them to do so.

> Although the government may not place obstances in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. *Harris* v. *McCrae,* 448 U.S. 297, 100 S.Ct. 2671, at 2688 (1980).

It is clear that under Virginia law that a minor need not be required to obtain parental consent for an abortion performed in a public hospital.[2]

The Commonwealth under *Rowe* v. *Wade,* 410 U.S. 113 (1973) is entitled to enact statutes which reasonably regulate the preservation and protection of maternal health. The Virginia legislature has seen fit to require hospitalization in second

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[2] Section 54-325.2D.2. provides:

"A minor shall be deemed an adult for the purposes of consenting to: medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization."

trimester abortions. The evidence at trial revealed that complications occur in some cases. (A. 44-46). Moreover in *Gary-Northwest* v. *Bowen,* 451 U.S. _____ (1981), *affirming Mem,* 496 F.Supp. 894 (N.D. Ind. 1980), the court specifically held that a hospitalization requirement for second trimester abortions is constitutional based on the simple language in *Rowe* v. *Wade, supra.* Other cases have upheld the second trimester requirement: *Livingston* v. *New Jersey State Board of Medical Examiners,* 402 A.2d 967, *cert. denied,* 408 A.2d 800 (N.J. 1979); *Akron Center for Reproductive Health, Inc., et al.* v. *City of Akron,* 479 F.Supp. 1172, 1215 (N.D. Ohio 1979); *Wynn* v. *Scott,* 449 F.Supp. 1302 (N.D. Ill. 1979); *aff'd,* 599 F.2d 193 (7th Cir.), *appeal dismissed for lack of jurisdiction,* 439 U.S. 8 (1979).

In further response to the Appellant's argument, the Commonwealth relies on the opinion of the Virginia Supreme Court concerning this issue found on pages 18a through 19a of the Appellant's Jurisdictional Statement.

PARENTAL CONSENT.

As previously stated, the fact that the parental consent to a minor's abortion is required by certain *private* hospitals despite the statutory abrogation of such a requirement does not raise a due process or equal protection question of constitutional stature. The test is whether there exists a "government obstacle". *Harris* v. *McCrae,* 448 U.S. 297 (1980). Public hospitals in Virginia are not under statutory mandate to refuse abortions or require parental consent. *See* § 54-325.2D.2.

CONCLUSION

For the reasons set out, the Court should dismiss appellant's Assignment of Error II and affirm this case with respect to the remainder of the allegations presented.

Respectfully submitted,

MARSHALL COLEMAN,
Attorney General of Virginia

THOMAS D. BAGWELL,
Assistant Attorney General
Counsel of Record.

Thomas D. Bagwell
Assistant Attorney General
900 Fidelity Building
830 East Main Street
Richmond, Virginia 23219
(804) 786-6563

CERTIFICATE OF SERVICE

I, Thomas D. Bagwell, Assistant Attorney General of Virginia, Counsel of record for the Commonwealth in the captioned matter and member of the Bar of the Supreme Court of the United States do hereby certify that on or before October 30, 1981, three copies of the foregoing Motion to Dismiss and Motion to Affirm were mailed, first-class postage prepaid, to Roy Lucas, Esquire, ROY LUCAS & ASSOCIATES, P.C., Suite 424, 1055 Thomas Jefferson Street, N.W., Washington, D.C. 20007, Counsel of record for Appellant.

Thomas D. Bagwell
Assistant Attorney General
(804) 786-6563

Appellant's Brief

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No. 81-185

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Appellant,

v.

COMMONWEALTH OF VIRGINIA,
Appellee.

Appeal From The Supreme Court Of Virginia

BRIEF FOR APPELLANT

ROY LUCAS, *Counsel of Record*
LUCAS & ASSOCIATES, P.C.
Three Ten Constitution Avenue, N.E.
Washington, D.C. 20002
(202) 543-5115

WILLIAM P. MARSHALL
1515 Hague Avenue
St. Paul, MN. 55104

Of Counsel:
JOHN H. OBRION
BROWDER, RUSSELL, LITTLE,
MORRIS & BUTCHER
1200 Ross Building
Richmond, VA. 23219

PRESS OF BYRON S. ADAMS PRINTING, INC., WASHINGTON, D.C.

QUESTIONS PRESENTED

I. Whether the Virginia criminal abortion law was unconstitutionally applied in violation of the Due Process Clause, where lack of necessity for the abortion was not alleged in the indictment, not addressed in the prosecution's case, and not ruled upon by the trial court?

II. Whether the conviction must be reversed as violative of the Due Process Clause where the entire prosecution case presented *no evidence* that any act of Dr. Simopoulos in fact *caused* the demise of the fetus, and the sole prosecution medical witness admitted the lack of evidence?

III. Whether the *mandatory hospitalization* requirement of the Virginia abortion law abridges the rights of privacy and due process by unduly restricting access to second trimester abortions, criminalizing safe non-hospital practice, and delegating to hospitals the authority to ban such abortions altogether?

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TABLE OF AUTHORITIES

CASES: Page

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Commonwealth v. *Simopoulos*, 221 Va. 1059, 277 S.E.2d 194 (1981) ..... *passim*

Commonwealth v. *Stone*, 300 Mass. 160, 14 N.E.2d 158 (1938) 20

Corkey v. *Edwards*, 322 F.Supp. 1248 (W.D.N.C. 1971) 20

Cox Broadcasting Corp. v. *Cohn*, 420 U.S. 469 (1975) . 2

Davis v. *Virginia Ry. Co.*, 361 U.S. 354 (1959) 24

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Fitch v. *People*, 45 Colo. 298, 100 P. 1132 (1909) 20
Flournoy v. *Wiener*, 321 U.S. 253 (1944) 2
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Johnson v. *Florida*, 391 U.S. 596 (1969) 2
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Moore v. *City of East Cleveland*, 431 U.S. 494 (1977) . 10

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People v. *Gallardo*, 41 Cal.2d 57, 257 P.2d 57 (1953) .. 19
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People v. *Sarelli*, 34 Ill. App. 2d 380, 180 N.E.2d 711 (App. Ct. 1962) 19
Phillips v. *State*, 239 Miss. 399, 123 So. 2d 449 (1960) . 20
Planned Parenthood of Central Missouri v. *Danforth*, 428 U.S. 52 (1976) ..... *passim*
Reed v. *Church*, 175 Va. 284, 8 S.E.2d 285 (1940) 24
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Sandstrom v. *Montana*, 442 U.S. 510 (1979) 8, 20, 22
Schad v. *Borough of Mt. Ephraim*, 452 U.S. 61 (1981) 10, 34, 35
Simopoulos v. *Coleman*, C.A. 81-0476-A (E.D. Va. Sept. 2, 1981) 3
Simopoulos v. *Virginia State Bd. of Medicine*, No. 80-1431 (4th Cir. 1980) (not reported), vacated on other grounds, 644 F.2d 321 (4th Cir. 1981) 3
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Smith v. *Bentley*, 493 F.Supp. 916 (E.D. Ark. 1980) .. 19
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State v. *Bates*, 52 Wash. 2d 207, 324 P.2d 810 (1958) . 20
State v. *Brown*, 26 Del. 499, 85 A. 797 (1912) 19
State v. *Fitzgerald*, 188 Mo. App. 365, 174 S.W.2d 211 (1943) 20

Table of Authorities Continued

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State v. *Hunter*, 131 Minn. 252, 154 N.W. 1038 (1915) . 20
State v. *Jamieson*, 206 Kan. 491, 480 P.2d 87 (1971) .. 19
State v. *Keever*, 10 Ariz. App. 354, 458 P.2d 974 (Ct. App. 1969) 19
State v. *Montefoire*, 95 Vt. 508, 116 A. 77 (1922) 20
State v. *Orsini*, 155 Conn. 357, 232 A.2d 907 (1967) ... 19
State v. *Redman*, 126 Me. 167, 136 A. 817 (1927) 20
State v. *St. Angelo*, 72 R.I. 412, 52 A.2d 513 (1947) .. 20
State v. *Shortridge*, 54 N.D. 779, 211 N.W. 336 (1926) 20
State v. *Snyder*, 244 Ia. 1244, 59 N.W.2d 233 (1953) .. 19
State v. *Wells*, 35 Utah 400, 100 P. 681 (1909) 20
Terry v. *Commonwealth*, 171 Va. 505, 198 S.E. 911 (1938) 27
Thompson v. *Louisville*, 362 U.S. 199 (1960) 21
Tot v. *United States*, 319 U.S. 463 (1943) 14, 16
United States v. *Vuitch*, 402 U.S. 62 M (1971) 7, 12, 13, 14, 15, 16, 17, 19
University of Texas v. *Camenisch*, 451 U.S. 390 (1981) 30
Vachon v. *New Hampshire*, 414 U.S. 478 (1974) 8, 21
Whalen v. *Roe*, 429 U.S. 589 (1977) 32
Wilson v. *State*, 41 Tex. Cr. App. 179, 153 S.W. 122 (1899) 25
Winship, In re, 397 U.S. 358 (1970) 7, 13, 17, 21

STATUTES AND REGULATIONS:

D.C. Code, § 22-201 16
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National Health Planning and Development Act, 42 U.S.C. § 300 k(a)(4) 43
Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) 4
1848 Va. Acts, Tit. II, c. 3, § 9 28

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U.S. Code, Title 28, § 1257	2
U.S. Code, Title 28, § 2103	2
Va. Code, § 18.1-145	38
Va. Code, § 18.1-62	28
Va. Code, § 18.2-10(d)	28
Va. Code, § 18.2-71	2, 11, 15, 38, 45, 46
Va. Code, § 18.2-72	2, 11, 15
Va. Code, § 18.2-73	2, 11, 15
Va. Code, § 18.2-74	11
Va. Code, § 18.2-74.1	2, 11, 15
Va. Code, § 32.1-145	38
Va. Code, § 54.321.2	28
Va. Code, § 4401(1919)	28

OTHER AUTHORITIES:

Abortion: Need, Services and Policies, Virginia, (Alan Guttmacher Institute 1979) 31, 32

American Public Health Association, Resolution, "The Right to Second Trimester Abortion" (Adopted November, 1979) ..... ADDENDUM 80

Ashford & Risinger, *Presumptions, Assumptions, and Due Process in Criminal Cases: A Theoretical Overview*, 79 YALE L.J. 165 (1967) 14

Center for Disease Control: Abortion Surveillance 1978 (1980) 29

Craft, *Abortion Update in Great Britain*, ABORTION AND STERILIZATION (J. Hodgson ed. 1980) 39

11 *Million Teenagers* (Alan Guttmacher Institute 1976) 5, 41

Grimes, *The Brief for Hypertonic Saline*, 15 Contemporary Ob/Gyn 29-38 (June 1980) ..... ADDENDUM 29

Grimes, *Methods of Midtrimester Abortion: Which is Safest?*, 15 Int. J. Gyn. & Obst. 184 (1977) ..... ADDENDUM 75

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Henshaw, *Abortion Services in the United States, 1979 and 1980*, 14 Family Planning Perspectives 5-15 (1982) 29, 32, 40

Hern, *Outpatient Second-Trimester D & E Abortion Through 24 Menstrual Weeks Gestation*, 16 Advances in Planned Parenthood 7 (1981) 42

Hospital Mortality, P.A.S. Hospitals, United States, 1974-75, Table D: Ranking of Operation Groups by Fatality Rate, Number of Patients, and Number of Deaths 298-311 (1977) ..... ADDENDUM 67

Kerenyi, *Intraamniotic Techniques*, ABORTION AND STERILIZATION 359 (J. Hodgson, ed. 1980) 41

Kerenyi, *Outpatient Intra-amniotic Injection of Hypertonic Saline*, 14 Clin. Obst. & Gyn. 137 (1971) ..... ADDENDUM 35

Klein, *Antecedents of Teenage Pregnancy*, 21 Clinical Obst. & Gyn. 1151 (1971) 27

LeBolt, *Mortality from Abortion and Childbirth: Are the Populations Comparable?*, 248 J.A.M.A. 188 (1982) 40

Nathanson, *Ostetricians' Attitudes and Hospital Abortion Services*, 12 Family Planning Perspectives 26 (Jan./Feb. 1980) ..... ADDENDUM 60

Neubardt & Schulman, TECHNIQUES OF ABORTION (1972) ..... ADDENDUM 51

Powell, *Of Politics and the Court*, 1982 YEARBOOK: SUPREME COURT HISTORICAL SOCIETY 37

Schulman, *Second Trimester Abortion: Techniques and Complications*, 6 GYNECOLOGY & OBSTETRICS c.60, at 10 (J. Sciarra ed. 1982) 41

Simms, *The Evolution of Abortion and Sterilization Legislation in the United Kingdom*, ABORTION AND STERILIZATION 57 (J. Hodgson ed. 1980) 39

Shelton, *Abortion Utilization: Does Travel Distance Matter*, 8 Family Planning Perspectives 260 (1976) ..... ADDENDUM 57

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Soderstrom & Hayden, *Outpatient Saline Abortion: A Review of 1,000 Cases*, 12 Advances in Planned Parenthood 98 (1978) ..... ADDENDUM 24

Stern, R. & Gressman, E., SUPREME COURT PRACTICE (5th ed. 1978) 2

Teicher, *A Solution to the Chronic Problem of Living: Adolescent Attempted Suicide*, CURRENT ISSUES IN ADOLESCENT PSYCHIATRY, 124 (J. Schooler, ed. 1973) 18

Virginia Vital Statistics for 1979 (Department of Health, 1980) 33, 34

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

No. 81-185

CHRIS SIMOPOULOS, M.D., FACOG,

Appellant,

v.

COMMONWEALTH OF VIRGINIA,

Appellee.

Appeal From The Supreme Court Of Virginia

BRIEF FOR APPELLANT

OPINIONS BELOW

The April 24, 1981, decision of the Supreme Court of Virginia is reported as *Commonwealth* v. *Simopoulos*, 221 Va. 1059, 277 S.E.2d 194 (1981). The text is set out in Appendix A to the Jurisdictional Statement at 1a-21a.

The April 16, 1980, judgment of conviction by the Circuit Court of Fairfax County, Virginia, is not officially reported. The text of the judgment and sentencing are set out verbatim in Appendix B to the Jurisdictional Statement at 23a-26a.

JURISDICTION

This Court has jurisdiction over the entire appeal[1] under Sections 1257(2), (3), & 2103, Title 28, U.S. CODE. The Supreme Court of Virginia entered judgment on April 24, 1981. (J.S. 31a). The notice of appeal to this Court was timely filed July 6, 1981. (J.S. 33a).

The decision below upheld the Virginia abortion law against federal constitutional claims.

STATUTE INVOLVED

The only Virginia abortion statute under which Dr. Simopoulos was prosecuted is VA. CODE § 18.2-71.[2] The entire statutory scheme is set out in note 2 of the Virginia Supreme Court opinion. (J.S. 4a-6a).

STATEMENT OF THE CASE

Chris Simopoulos, M.D., testified in his own defense. (J.A. 361-438). He is a practicing obstetrician-gynecologist in north-

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[1] The Commonwealth contends that Question II is an untimely certiorari matter. *Motion to Dismiss* at 6. No authorities are cited. This Court has held, however, that an appellant properly before the Court may include in the questions presented "any other denial of federal right whether or not capable in itself of being brought here by appeal. . . ." *Flournoy* v. *Wiener*, 321 U.S. 253, 263 (1944). *Johnson* v. *Florida*, 391 U.S. 596 (1968) (per curiam), is an example of appellate jurisdiction exercised to vacate a conviction where "the record is lacking in any evidence to support the judgment." 391 U.S. at 598. *Accord*, *Gomez* v. *Perez*, 409 U.S. 535, 537 n.2 (1973); *Cox Broadcasting Corp.* v. *Cohn*, 420 U.S. 469 (1975). *See generally* R. STERN & E. GRESSMAN, SUPREME COURT PRACTICE 168-172 (5th ed. 1978).

[2] The indictment appears in J.S. 3-4.

The indictment alleges the exceptions as to length of pregnancy (second trimester) and location outside of a hospital. VA. CODE § 18.2-72, § 18.2-73. However, it does not negate the exception in VA. CODE § 18.2-74.1 (medical necessity).

ern Virginia.[3] (J.A. 83). He trained as a resident at the New Jersey College of Medicine and is certified in ob/gyn by the American Board of Obstetrics and Gynecology. (J.A. 365, 363). He is also certified in emergency medical treatment by the American Heart Association. (J.A. 376). He was at all times pertinent to this case a member of the medical staff at Fairfax Hospital, Commonwealth Doctor's Hospital, Potomac Hospital, and Fairfax Surgery Center. (J.A. 366).

Dr. Simopoulos was initially licensed in Virginia in 1969.[4] He has lived with his wife and four sons in Fairfax Station, Virginia.[5]

His ob/gyn practice in November of 1979 consisted of office practice in Woodbridge, Virginia, hospital practice at one of the four institutions mentioned, and office-gyn practice at his well-equipped clinic in Falls Church, known as the American Women's Clinic. (J.A. 373). The clinic (AWC) has an operating room, O.R. lighting, and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand.[6] (J.A. 376).

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[3] The Virginia State Board of Medicine restored Dr. Simopoulos' license to practice, after the conviction, on July 31, 1981, but imposed a two year condition that he not perform any first or *second* trimester abortions at all. That condition is at issue in *Simopoulos* v. *Coleman*, C.A. 81-0476-A (E.D. Va. Sept. 2, 1981) (appeal pending).

[4] He completed his M.D. in 1966 at the University of Athens Faculty of Medicine. Dr. Simopoulos came from humble rural origins in the mountains of Macedonia, Greece. His background and career were described by the trial court as "impressive" and "something to be proud of." (J.A. 483).

[5] Father Theodore Chelpon described Dr. Simopoulos as "a very active member of my parish . . . a truthful man and a faithful man and a man devoted to his family, a man devoted to his duty to his fellow man as they need his services." (J.A. 445, 446).

[6] Blood would be available in the rare case upon transfer to a nearby hospital after stabilization with other fluids. (J.A. 173, 381). There is no evidence that outpatient clinics keep blood on hand or are

Each of three medical ob/gyn experts visited the clinic independently to determine its suitability for outpatient saline instillation. (J.A. 20, 96, 327). Dr. Harold Schulman, Chairman of Ob/Gyn at Albert Einstein in New York, had conducted a then-pioneering major study eleven years ago on outpatient saline abortion practice.[7] He described the equipment in the AWC clinic as more extensive than that in his own 1971 study. (J.A. 26). Dr. Peter Soyster of George Washington University and Dr. Samuel Belinsky both stated that the AWC facility was better equipped than the Fairfax Hospital unit for outpatient saline instillation. (J.A. 96, 327).

The prosecution arrest team viewed the clinic and photographed it extensively.[8] The prosecutor did not offer the photographs as evidence at any time, nor did he present any direct or rebuttal medical evidence critical of Dr. Simopoulos' practice or clinic.

The young woman involved in this case, P.M., was a high school senior, employed, and almost 18 when[9] she came to Dr.

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required to do so. Even if Dr. Simopoulos had chosen to seek a certificate of need and a special license for AWC as an Outpatient Hospital, there would be no requirement of a blood bank on the site. *Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia*, secs. 43.5, 64.2.5 (1977).

[7] The Virginia Supreme Court cited this study as authoritative. (J.S. 2a). It was introduced into evidence and is part of the Record. (Df. Ex. 9, J.A. 151).

Similar studies are included in the "Addendum of Medical/Statistical/Legal Documents Lodged With Brief for Appellant." (cited hereafter ADDENDUM ____). *See* ADDENDUM, Documents #4, #5, #6, #7, #8 at 18, 24, 29, 35, 51 for the principal studies.

[8] The sole prosecution medical witness did not view the clinic at any time. He was not a surgeon nor an ob/gyn, but a pathologist. (J.A. 230).

[9] These factors would take P.M. outside of the class represented in *H.L.* v. *Matheson*, 450 U.S. 398 (1981).

Simopoulos on November 8 and 10, 1979 (J.A. 263, 265, 270). P.M. knew she was pregnant for about sixteen weeks[10] before. (J.A. 177). She had called around to other clinics to inquire about costs. (J.A. 281).[11]

P.M. was scared and seemed terrified at the prospect of her parents finding out. (J.A. 283, 383). This fear is not infrequent, though it may be unjustified in a significant number of cases. See *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 103 (1976) (Stevens, J., concurring in part).

Dr. Simopoulos had solid grounds to be concerned for her life and health based on his experience over many years as a gynecologist.[12] He explained the reasons:

> "Well, these patients are very desperate. Patients seeking second trimester abortions are, as a rule, very young, very poor, uneducated, ignorant and very desperate. They want to get an abortion no matter what."
>
> "I have seen cases where self-destructive or self-induced abortion took place with complications. I have seen patients who committed suicide because they could not get an abortion and they did not want their parents or relatives to know about it, and I strongly suspect that everytime there is a suicide of a pregnant young lady as being the cause of it." (J.A. 395).

Dr. Simopoulos encouraged her to confide with her parents, to go home, and consider telling them. (J.A. 385). He discussed the alternative with her of continuing the pregnancy to term

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[10] A disproportionate number of midtrimester abortion patients are minors because of several reasons—confusion, denial, financial problems, relationship difficulties, and other factors. See generally 11 MILLION TEENAGERS 23-29 (Alan Guttmacher Institute 1976). Justice Rehnquist cited this study with approval in *Michael M.* v. *Sonoma County Superior Court*, 450 U.S. 464, 470 (1981).

[11] Costs and parental consent policies would have made calls to hospitals futile. (J.A. 100, 328-329, 391).

[12] The maternal death risk "for 15-19-year-olds is 13 percent greater than for mothers in their early 20s." 11 MILLION TEENAGERS 23 (1976).

and delivery.[13] (J.A. 384). She did go home but never advised her parents.

Two days later, P.M. returned for a saline injection. (J.A. 270). Dr. Simopoulos was concerned about her health and well-being if he turned her away. (J.A. 395).

Dr. Simopoulos administered the saline injection to P.M. in the clinic operation facility. (J.A. 271). Both he and the nurse were present for the entire procedure. (J.A. 259). Although P.M. was unable to recall being instructed to meet the doctor at Fairfax Hospital when labor began (J.A. 294), both the nurse and receptionist testified that Dr. Simopoulos advised her and provided written post-injection instructions (J.A. 254) as to when to report to the hospital emergency room. (J.A. 221).

The instructions (Df. Ex. 3, J.A. 199) state under "WHAT TO DO":

> ". . .4. Report to the hospital when you begin having contractions that are 10 minutes apart and lasting 30 seconds or more. . . .
>
> "5. Come to the hospital when your bag of waters breaks, regardless of whether you have contractions or not."

P.M. almost left the instructions. The nurse had to follow her into the hallway. (J.A. 186). P.M. and her boyfriend then went to the Howard Johnson's Motel in Springfield, Virginia, several miles away (J.A. 208), beyond the control of Dr. Simopoulos. (J.A. 278).

P.M. aborted her fetus at 11:00 Monday morning in the motel bathroom, ten hours after labor began. (J.A. 276). Although she had read the post-injection instruction sheet (J.A. 284) and had received instructions to call when labor began (J.A. 397), she never called. Alone and scared (J.A. 295), she left the fetus, follow-up instructions and pain medication at the motel. (J.A.

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[13] Dr. Simopoulos performs many obstetrical deliveries in his practice also. (J.A. 384, 385).

51-54). Her boyfriend took her directly home. (J.A. 298). Testimony showed, and she admitted, that she needed no medical treatment after the abortion. (J.A. 298). However, she went to a hospital at a police officer's suggestion. (J.A. 298). Police found the fetus later that day (J.A. 51) and opened an investigation. The police agreed that Dr. Simopoulos cooperated fully and honestly. (J.A. 229).

SUMMARY OF ARGUMENT

I. VA. CODE § 18.2-71 was unconstitutionally applied to Dr. Simopoulos. Lack of medical necessity for the abortion was not alleged in the indictment (J.S. 3), not addressed in the prosecution's case, and not mentioned by the trier of fact. The burdens of persuasion and going forward with the evidence must be imposed on the State in a criminal prosecution for performing an illegal abortion. *United States* v. *Vuitch*, 402 U.S. 62 (1971). The Virginia high court attempted to distinguish *Vuitch* by construing the Virginia medical necessity defense as if it were a separate, unrelated statute.

If the Virginia statute is so construed and the medical necessity proviso and others like it are treated as independent statutory defenses, then VA. CODE § 18.2-71 bans all abortions in the first instance, subject only to the raising of separate defenses, even in the case of first trimester abortions. This directly contravenes the holdings in *Roe* v. *Wade*, 410 U.S. 113 (1973), and *Doe* v. *Bolton*, 410 U.S. 179 (1973). It makes criminal what is constitutionally protected.

Further, the Virginia Court did not successfully distinguish the *Vuitch* opinion. The Virginia abortion statute is not functionally dissimilar to the statute addressed in *Vuitch*.

The requirement that the defendant move forward on the issue of medical necessity impermissibly presumes this issue against him in violation of *Vuitch*, and *In re Winship*, 397 U.S. 358 (1970). This allocation of burden presumes a physician will not act in accordance with his medical judgment. Such a presumption is at odds with the view of the physician in our

society and the role the physician holds in the abortion decision. *Colautti* v. *Franklin*, 439 U.S. 379, 396 (1979); *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973).

The Virginia Court stated that the State has the burden of persuasion on the medical necessity issue. This was required by *Patterson* v. *New York*, 432 U.S. 197 (1977), and *Mullaney* v. *Wilbur*, 421 U.S. 684 (1975). It parallels the rule in most state jurisdictions and in England. See *Rex* v. *Bourne*, [1939] 1 K.B. 687.

The Virginia Court also held that the prosecution met this burden. The Record shows, however, that the prosecution never even argued or presented evidence as to non-necessity. Nothing in the Record suggests that the trial court placed that burden on the Commonwealth. That possibility parallels the majority grounds for reversal in *Sandstrom* v. *Montana*, 442 U.S. 510 (1979).

Since the prosecution did not argue or present evidence on medical necessity, there is no evidence in the Record which could constitutionally support a conviction. *Vachon* v. *New Hampshire*, 414 U.S. 478 (1974) (per curiam). There is certainly insufficient evidence on this issue to support a conviction beyond a reasonable doubt. *Jackson* v. *Virginia*, 443 U.S. 307, 316 (1979). The factors relied upon in upholding the conviction were non-probative. No medical testimony supporting the prosecution on the issue was provided, although the inherently medical nature of the abortion decision makes the inclusion of medical evidence mandatory. Similarly, the conviction may not stand because of no evidence or insufficient evidence of the physician's intent to commit a non-necessary abortion. *Colautti* v. *Franklin*, 439 U.S. 379, 401 (1979).

II. The prosecution failed to present any medical evidence that acts of Dr. Simopoulos in fact *caused* the demise of the fetus. The Virginia Supreme Court erroneously relied upon tenuous circumstantial factors and the absence of defense proof of some other cause to sustain the verdict. (J.S. 11a). There was insufficient evidence for a rational trier of fact to

find causation beyond a reasonable doubt. *Jackson* v. *Virginia*, 443 U.S. 307, 316 (1979).

The sole medical expert for the prosecution, Dr. Wiecking, testified on direct for only five transcript pages (Tr., Apr. 15, 1980, pp. 39-43; J.A. 230-236). His autopsy (Pf. Ex. 7, J.A. 315) concluded that "immaturity" was the cause of death. He did not dispute the investigative report statement that the "manner of death was natural." (J.A. 237). The Commonwealth presented no evidence of fetal viability or vital signs at any time. There were no physical, chemical, or other tests done on the fetus to detect a fatal saline impact, or even the time of death. Dr. Wiecking admitted he could not exclude possible causes of death other than saline (J.A. 240).

There was insufficient evidence even to reach a jury in a civil malpractice proceeding.

III. The Virginia statutory hospital requirement criminalizes all non-hospital second trimester abortions. It imposes an unconstitutional burden on the right of privacy and has negative health consequences. *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 76-79 (1976). This criminal prohibition sharply restricts the availability of abortions after the first trimester by granting a monopoly to the few licensed hospitals which will permit the post-12 week abortions. Compare *Carey* v. *Population Services International*, 431 U.S. 678, 712 (1977) (Stevens, J., concurring).

This Court has held other second trimester criminal statutes unconstitutional where not reasonably related to a compelling state interest, not narrowly drawn to effectuate such interests, or too vague in practice. See *Colautti* v. *Franklin*, 439 U.S. 379, 397 (1979); *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*; *Doe* v. *Bolton*, 410 U.S. 179, 193-195 (1973).[14]

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[14] *Roe* and *Doe* did not have occasion to examine the issue of criminal statutes banning only second trimester abortions in safe alternative facilities under circumstances where childbirth would

The decisions in *Roe*, *Doe*, *Danforth*, and *Colautti*, reinforced by evidence in the record and objective scientific findings, strongly support a judgment that the mandatory hospitalization prohibition does not "measurably contribute to the . . . purposes which the State advances as justification for the restriction." *Carey* v. *Population Services International*, 431 U.S. 678, 702 (1977) (White, J., concurring). In a case involving such "intrusive regulation" on the rights of privacy, "the usual judicial deference to the legislature is inappropriate." *Moore* v. *City of East Cleveland*, 431 U.S. 494, 499 (1977) (zoning regulation of familial relations invalid).

The Virginia hospital requirement in the confines of this case has even more dramatic constitutional defects. The burden on the patient's right of privacy is more severe than usual. P.M. was a mature, working minor who would have had to travel some distance to a jurisdiction (i.e., D.C., N.C., or W. Va.) where no criminal statute mandated hospitalization. The burden of unnecessary travel to exercise a constitutional right has met with disapproval in this Court. E.g., *Schad* v. *Borough of Mt. Ephraim*, 452 U.S. 61, 76-77 (1981); *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 77 n.12 (1976); *Mississippi University for Women* v. *Hogan*, ___ U.S. ___, ___, n.8 (1982) (travel to nondiscriminatory nursing school).

P.M. had no choice in northern Virginia unless a non-hospital clinic would help her. Dr. Simopoulos' facility was well-equipped for safe, healthy management of a patient such as P.M. The procedure used by Dr. Simopoulos was safe and had been accepted by experience and the scientific literature for almost ten years. (J.A. 25-29; J.A. 94-97; J.A. 324-327; *see also* ADDENDUM Documents #4, #5, #6, #7, #8 at 18, 24, 29, 35, 51). There was no constitutionally permissible basis for applying the statute to these facts.

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have been more dangerous. See also *Gary-Northwest* v. *Orr*, 451 U.S. 943 (1981), *aff'g mem.* 496 F. Supp. 894 (N.D. Ind. 1980) (three-judge court) (district court refusal to reconsider denial of preliminary injunction five years earlier).

ARGUMENT

I. THE VIRGINIA ABORTION LAW WAS UNCONSTITUTIONALLY APPLIED IN VIOLATION OF THE DUE PROCESS CLAUSE, WHERE LACK OF NECESSITY FOR THE ABORTION WAS NOT ALLEGED IN THE INDICTMENT, NOT ADDRESSED IN THE PROSECUTION'S CASE, AND NOT RULED UPON BY THE TRIAL COURT.

A. Introduction And Overview

A four part Virginia statutory scheme is involved in this case. VA. CODE § 18.2-71 provides as follows:

> "Sec. 18.2-71. Producing abortion or miscarriage, etc.; penalty.—*Except as provided in other sections* of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony." (Emphasis added).

In three following sections the Virginia Code sets forth exceptions to this statute. First, there is no criminal liability if the abortion is performed within the first trimester (VA. CODE § 18.2-72). Second, it is a defense if the abortion is performed in a licensed hospital in the second trimester (§ 18.2-73). Third, the abortion is not illegal if necessary to save the life of the woman (§ 18.2-74.1).[15]

The indictment (J.S. 3-4) alleged a violation of VA. CODE § 18.2-71. It expressly negated any defense of hospitalization under VA. CODE § 18.2-73. It also negated any defense of "first trimester" under VA. CODE § 18.2-72. The indictment did not, however, attempt to rebut the third possibility—medical necessity for the abortion under VA. CODE § 18.2-74.1.

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[15] A fourth defense, unrelated to this case, allows for abortions during the third trimester of pregnancy under certain circumstances (§ 18.2-74). There was no evidence or contention of viability in this case. (J.A. 238-239).

This defect in the indictment was raised by defense counsel in argument on pre-trial motions to dismiss. (J.A. 195-197). This argument placed the medical necessity question in the case, as it had not been in the written motion.

The trial court denied the motion. (J.A. 197). The prosecutor at trial, as in his indictment, ignored his burden on the medical necessity issue. It was not mentioned in his opening argument. (J.A. 206-209). He introduced no evidence as to the lack of medical necessity from his own witnesses. He offered no expert testimony on the subject (J.A. 230-236), and he did not mention the issue in his closing argument. (J.A. 449-453). Since the prosecutor did not acknowledge and then failed to meet his burden on the issue, defendant moved for a directed verdict at the close of the state's case (J.A. 300)[16] and renewed the motion at the close of trial (J.A. 447-449). All motions were denied by the trial court. (J.A. 197, 307, 499). The trial court at no time, however, ruled on the issue of whose burden it was to plead and to prove the medical necessity issue, nor whether that burden was met.

Initially, the prosecution's failure to meet its burden of alleging lack of medical necessity in the indictment may be seen as a violation of *United States* v. *Vuitch*, 402 U.S. 62 (1971). Similarly the prosecution's failure to meet its burden of persuasion at trial violated *Vuitch*, *Patterson* v. *New York*, 432 U.S. 117 (1977), and *Mullaney* v. *Wilbur*, 421 U.S. 684 (1975).

The Virginia Supreme Court first tried to extricate the prosecution from its failure to indict by purportedly construing the Virginia statute to distinguish *Vuitch*. Second, it tried to avoid the burden of persuasion issue by ostensibly agreeing with defendant's argument on this point while simultaneously characterizing the facts as meeting the prosecution's burden.

In so doing, however, the Virginia Supreme Court compounded the constitutional issues. Not only did the Court

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[16] This is characterized a "Motion to Strike" in Virginia practice. (J.A. 300).

unpersuasively distinguish *Vuitch*, but its new statutory construction ran directly afoul of *Roe* v. *Wade*, 410 U.S. 113 (1973). Similarly the attempt to circumvent *Vuitch-Mullaney-Patterson* resulted in the case being directly opposed to this Court's holding in *Jackson* v. *Virginia*, 443 U.S. 307 (1979), and *In re Winship*, 397 U.S. 358 (1970).

B. Burden Of Establishing Lack Of Medical Necessity—Failure Of Prosecution To Indict And Go Forward

In *United States* v. *Vuitch*, *supra*, this Court held that when an exception is incorporated into an enacting clause of a criminal statute, the burden is on the prosecution to plead and prove that the defendant is not within that exception. 402 U.S. at 71. In order to save the indictment the Virginia Court construed the statute as not incorporating the medical necessity defense within its enacting clause. That factor was said to distinguish the case at bar from *Vuitch* (J.S. 10a). In this manner the Virginia Court sought to avoid the *Vuitch* holding.

1. The statutory construction engaged in by the Virginia Supreme Court abridges the central privacy rights protected by Roe v. Wade.

The lower court cited § 18.2-71 as the independent, self-contained enacting clause. The language "except as provided in other sections of this article," however, was read out of this subsection. The Virginia Court had to do so in order to avoid *Vuitch* and maintain that the statutory defenses were not incorporated in the enacting clause.[17]

This construction makes all abortions in Virginia indictable and illegal. Under the lower court's analysis, a claim that the abortion was performed in a hospital, or during the first trimester of pregnancy, or was necessary for life or health, is relegated to an affirmative defense instead of a constitutional right. As such it will be presumptively found against the de-

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[17] See pp. 15-17 & notes, *infra*.

fendant if not raised. In *United States* v. *Vuitch*, *supra*, the Court cautioned against the use of such presumptions. It noted that a statute which "'presumed' guilt whenever the mere fact of abortion was established would at the least present serious constitutional problems. . . ." 402 U.S. at 70. See also *Patterson* v. *New York*, 432 U.S. 197, 230 (Powell, J., dissenting).[18]

Here the "enacting clause" does not even state a crime. It outlaws abortion, an act this court has expressly held not to be a crime. *Roe* v. *Wade*, 410 U.S. 113 (1973). This the legislature may not do. *Compare Coates* v. *Cincinnati*, 402 U.S. 611, 616 (1971) (an ordinance abridging free speech makes "a crime out of what under the Constitution cannot be a crime."). Moreover, not only is abortion *not* a crime, it *is* a constitutionally protected right. *Roe* v. *Wade*, *supra*.[19] Even before *Roe*, this Court in *Vuitch* cautioned as to the constitutionality of statutes such as the one construed by the Virginia Court.

After *Roe*, the unconstitutionality of such a statutory construction is beyond dispute. It is as if the legislature sought to regulate a protected activity such as speech by outlawing all speech subject to the affirmative defense that such speech was not "directed to inciting or producing imminent lawless action

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[18] Justice Powell's concern was echoed in the majority opinion. The majority held the legislature cannot "validly command that the finding of an indictment, or mere proof of the identify of the accused, should create a presumption of the existence of all the facts essential to guilt. *Tot* v. *United States*, 319 U.S. 463, 469 (1943). See also *Speiser* v. *Randall*, 357 U.S. 513, 523-525 (1958)." 432 U.S. at 210.

[19] In short, the state, according to its highest Court, has attempted to distinguish the crime of illegal abortion from the defense of medical necessity. The two cannot be separated. In some circumstances it is true that what is a crime and what is a defense are not easily distinguishable. Ashford & Risinger, *Presumptions, Assumptions, and Due Process in Criminal Cases: A Theoretical Overview*, 79 YALE L.J. 165, 188 (1967). In the abortion context, however, the Court has spoken. Criminal abortions can only be those that are outside of the *Roe* v. *Wade* parameters and not medically necessary.

and [was] likely to incite or produce such action." See *Brandenburg* v. *Ohio*, 395 U.S. 444, 447 (1969). Such a regulation would chill speech and subject persons to potentially discriminatory enforcement. See *Coates* v. *Cincinnati*, *supra*. Similarly, the physician's willingness to perform an abortion would be chilled if every abortion was indictable subject only to an affirmative defense. See *Colautti* v. *Franklin*, 439 U.S. 379, 396-398 (1979).[20] The statute as construed by the Supreme Court of Virginia is thus void on its face.

2. The Virginia Court's construction of its statute does not survive United States v. Vuitch.

The lower Court did not properly construe the *Vuitch* case. It sought to distinguish *Vuitch* simply on the location of the statutory defenses. The *location* of the medical necessity exception in the basic Virginia abortion statute, however, is not functionally "subsequent to the enacting clause." (J.S. 10a). Rather, it is expressly absorbed into the enacting clause itself.

The principal abortion statute, VA. CODE § 18.2-71, incorporates § 18.2-74.1 on necessity by reference:

> "Sec. 18.2-71. . . . Except as provided in other *sections* of this article . . ." (J.S. 4a, n.2) (emphasis added).

This is precisely equivalent to stating:

> Except when "necessary . . . in order to save her life . . ." (§ 18.2-74.1) or ". . . in a hospital licensed by the State . . ." (§ 18.2-73) or "during the first trimester of pregnancy. . . . (§ 18.2-72)."

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[20] "[A] statute imposing strict civil and criminal liability for an erroneous determination . . . could have a profound chilling effect on the willingness of physicians to perform abortions . . . in the manner indicated by their best medical judgment." 439 U.S. at 396.

The only difference is the location, or relocation, of three sentences. It is useful to set out the actual statute from *Vuitch*. D.C. CODE 22-201[21] provides:

> "Whoever . . . produce(s) an abortion or miscarriage on any woman, unless the same were done as necessary for the preservation of the mother's life or health . . . shall be imprisoned . . ." 402 U.S. at 67-68.

Surely this Court would not have ruled differently in *Vuitch* if the drafters of D.C. CODE § 22-201 had used the Virginia format. Yet, the analysis of the lower Court allows the result to be dictated by nothing more than the location of a moveable clause. Thus, under a straightforward application of *United States* v. *Vuitch*, 402 U.S. 62 (1971), the indictment and conviction cannot stand.

Moreover, *Vuitch* was not properly distinguished as to the burden to plead and come forward on non-necessity. Under the Virginia Court's interpretation of the statute, the burden to plead and come forward with evidence of medical necessity rested on the defendant. *Vuitch*, on the other hand, expressly stated: "The burden is on the prosecution to plead and prove that an abortion was not 'necessary for the preservation of the mother's life or health.'" 402 U.S. at 71.

A contrary presumption[22] cuts to the very heart of the role the Court has entrusted to the physician in the abortion deci-

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[21] Dr. Simopoulos could not have been criminally prosecuted under such a statute in the District of Columbia. There is no mandatory hospital requirement for all second trimester abortions in D.C. CODE § 22-201.

[22] As Justice Powell has noted, the placing of the burden of going forward with the evidence upon the defendant is normally permissible. *Patterson* v. *New York*, 432 U.S. at 230 (Powell, Jr., dissenting). However, as noted in *Barnes* v. *United States*, 412 U.S. 837 (1973), the burden may not be "freely shifted" to the defendant. *Id.* at 846, n. 11, citing *Tot* v. *United States*, 319 U.S. 463 (1943). A shift in the burden presumes the issue in question against the defendant. If the defendant presents no evidence, the issue will be resolved against

sion. The Court has stated "the abortion decision in all its aspects is inherently, and primarily, a medical decision." *Roe* v. *Wade*, 410 U.S. at 166. The Court has repeatedly held that the State may not impinge upon "the room the physician needs to make his best medical judgment." *Colautti* v. *Franklin*, 439 U.S. 397; *Doe* v. *Bolton*, 410 U.S. at 192. Compare *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 63-65 (1976). Moreover as the Chief Justice has explained, "The majority of physicians observe the standards of their profession and act only on the basis of carefully deliberated medical judgments relating to life and health." *Roe* v. *Wade*, 410 U.S. at 208 (Burger, C.J., concurring).[23] It cannot be presumed, as the state has here, that a physician will act without medical basis.

The Virginia presumption of medical non-necessity and its attendant burden of production imposed on the physician cannot stand. The failure of the prosecution to allege the lack of medical necessity and to move forward with evidence on this issue warrants reversal.

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him thereby implicating due process concerns. See *In re Winship*, 397 U.S. 358, 364 (1970).

Moreover, as *Speiser* v. *Randall*, 357 U.S. 513 (1958), indicates, placing the burden of production upon the defendant may be inappropriate when fundamental liberties are at stake. Here a fundamental liberty is involved. Indeed, central to the liberty the Court has recognized in its abortion decisions is the fundamental interest in protecting the woman's life and health. As the Court stated in *Harris* v. *McRae*, 448 U.S. 297, 316 (1980): "It could be argued that the freedom of a woman to decide whether to terminate her pregnancy for health reasons does in fact lie at the core of the constitutional liberty identified in *Wade*." See also *Roe* v. *Wade*, 410 U.S. at 153; *Id.* at 173 (Rehnquist, J., dissenting).

[23] See also *United States* v. *Vuitch*, 402 U.S. at 71: "Generally, doctors are encouraged by society's expectations, by the strictures of malpractice law and by their own professional standards to give their patients such treatment as is necessary to preserve their health."

C. Failure To Prove Beyond A Reasonable Doubt

1. Lack of evidence supporting the conviction generally.

As noted earlier, the prosecutor's opening statement made no reference to medical necessity. (J.A. 206-209).

When trial commenced, the prosecutor called five witnesses. Only one was a physician, Dr. David Wiecking. (J.A. 230). He had never heard of, examined, or talked with the patient (Tr., Apr. 15, 1980, p. 48). He gave no opinion negating or even concerning medical necessity for the abortion.

The prosecutor called no more expert witnesses to inquire of their opinions on medical necessity. He did not call and refused to identify such individuals known to him as the prior physicians of P.M., her parents, or her boyfriend, all of whom could have cast light on the question of medical necessity.

The submission by the defendant evidenced a good faith belief that the abortion was medically necessary. Dr. Simopoulos testified that P.M. was very apprehensive, depressed and fearful. (J.A. 383). She was terrified of her parents and did not want them to know about it. (J.A. 383-385). She cried and appeared to be far more depressed than the usual patient. (J.A. 383-384). He related that he had seen patients who committed suicide because they could not get an abortion and they did not want their parents or relatives to know about it. (J.A. 395).[24]

No rebuttal testimony was offered.

Again at closing argument, the prosecutor made no mention whatever of the medical necessity question. He stated the issue as:

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[24] In *H.L.* v. *Matheson*, 450 U.S. 398 (1981), it was noted that one-fourth of all female minors who attempt suicide, do so because they are pregnant. 450 U.S. at 439, n.26 (Marshall, J., dissenting), citing Teicher, *A Solution to the Chronic Problem of Living: Adolescent Attempted Suicide, Current Issues in Adolescent Psychiatry*, 124, 136 (J. Schooler, ed. 1973).

> "whether or not under the law this Defendant used some means to destroy the unborn child of (P.M.) and thereby terminate the life of that child." (J.A. 449-450).

Obviously the prosecution did not consider itself bound to prove anything about the medical necessity question which had been raised.

On appeal, defendant argued that failure to place the burden of proof upon the prosecutor violated due process.[25] The Virginia Court agreed in part with the defendant, and held that:

> "the Commonwealth has the burden of negating maternal health necessity beyond a reasonable doubt." (J.S. 10a).

A contrary ruling by the Court would have been unsupportable in light of *Patterson* v. *New York*, *supra*, *Mullaney* v. *Wilbur*, *supra*, and *United States* v. *Vuitch*.[26]

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[25] Defendant relied primarily on *United States* v. *Vuitch*, *supra*. See also *Patterson* v. *New York*, supra; *Mullaney* v. *Wilbur*, *supra*.

[26] The state has conceded that it must show lack of medical necessity beyond a reasonable doubt. See *Motion to Dismiss* at 5. This is compelled by previous decisions of the Court. Lack of medical necessity is clearly an element of unlawful abortion under the majority opinion in *Roe* v. *Wade*. Compare *Patterson* v. *New York*, *supra*; *Mullaney* v. *Wilbur*, *supra*. Additionally, there can be no culpability when a physician performs an abortion that is medically necessary. See *Mullaney* v. *Wilbur*, *supra*. Cf. *Engel* v. *Isaac*, ____ U.S. ____ (1982).

The vast majority of states before and after *Roe* have concluded that the burden of establishing lack of medical necessity rests on the prosecution. *State* v. *Keever*, 10 Ariz. App. 354, 458 P.2d 974 (Ct. App. 1969); *Smith* v. *Bentley*, 493 F. Supp. 916 (E.D. Ark. 1980); *People* v. *Gallardo*, 41 Cal.2d 57, 257 P.2d 29 (1953); *State* v. *Orsini*, 155 Conn. 357, 232 A.2d 907 (1967); *State* v. *Brown*, 26 Del. 499, 85 A. 797 (1912); *Holloway* v. *State*, 90 Ga. 86, 82 S.E.2d 235 (1954); *People* v. *Sarelli*, 34 Ill. App.2d 380, 180 N.E.2d 711 (App. Ct. 1962); *State* v. *Snyder*, 244 Iowa 1244, 59 N.W.2d 233 (1953); *Grecu* v. *State*, 233 Ind. 424, 120 N.E.2d 179 (1954); *State* v. *Jamieson*, 206 Kan. 491, 480 P.2d 87 (1971); *Fitch* v. *Commonwealth*, 291 Ky. 702, 165 S.W.2d 558

However, the court below concluded that the prosecutor had met his burden. This result is unsupportable given the total absence of presentation and/or argument on the medical necessity issue in the prosecution's case, and the absence of pertinent findings by the trial court.

A more likely conclusion from the Record is that the trial court placed the dual burdens of proof and presenting evidence as to necessity upon the defendant. This possibility alone requires reversal under *Sandstrom* v. *Montana*, 442 U.S. 510 (1979) (reversing a conviction where the trier of fact may have considered the burden of proof to be on the defendant).

Nonetheless, in its effort to uphold the conviction, the Supreme Court of Virginia took over the trial function and found the "evidence fully sufficient to refute any claim of maternal

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(1942); *State* v. *Redman*, 126 Me. 167, 136 A. 817 (1927); *Commonwealth* v. *Stone*, 300 Mass. 160, 14 N.E.2d 158 (1938); *People* v. *Bricker*, 42 Mich. App. 352, 201 N.W.2d 647 (1972), *aff'd*, 208 N.W.2d 172 (Mich. 1973); *State* v. *Hunter*, 131 Minn. 252, 154 N.W. 1038 (1915); *Phillips* v. *State*, 239 Miss. 399, 123 So.2d 449 (1960); *State* v. *Fitzgerald*, 188 Mo. App. 365, 174 S.W.2d 211 (1943); *People* v. *Harrison*, 40 Misc. 2d 601, 243 N.Y.S.2d 432 (N.Y.Sup. Ct. 1963); *Corkey* v. *Edwards*, 322 F. Supp. 1248 (W.D.N.C. 1971); *State* v. *Shortridge*, 54 N.D. 779, 211 N.W. 336 (1926); *Oregon* v. *Elliot*, 206 Or. 82, 289 P.2d 1075 (1955); *State* v. *St. Angelo*, 72 R.I. 412, 52 A.2d 513 (1947); *State* v. *Wells*, 35 Utah 400, 100 P. 681, (1909); *State* v. *Montifoire*, 95 Vt. 508, 116 A. 77 (1922); *State* v. *Bates*, 54 Wash.2d 207, 324 P.2d 810 (1958); *Hatchard* v. *State*, 79 Wis. 357, 48 N.W. 380 (1881).

But see, *Lingle* v. *State*, 51 Ala. 210, 283 So.2d 660 (1973), and *Fitch* v. *People*, 45 Colo. 298, 100 P. 1132 (1909), where the burden of proving medical necessity is on the defendant.

English law also places the burden on the Crown to show bad faith and lack of necessity. This was true in England both before and after the ABORTION ACT OF 1967, 15 & 16 ELIZ. 2, c.87. See *Rex* v. *Bourne* [1939] 1 K.B. 687, discussed in *Roe* v. *Wade*, 410 U.S. 113, 136-38 (1973).

health necessity." (J.S. 10a).[27] The Court reached this conclusion based upon only two matters.

First, the Court relied on the defendant's notes that P.M.'s condition was "normal" in her initial visit to the clinic. (J.S. 10a). No foundation was presented with respect to these notes to indicate that they had any relationship to the psychological and psychiatric concern which prompted Dr. Simopoulos' prognosis. The term "normal," although unexplained, would most likely refer to physical vital signs at the time of examination, not to the mental turmoil which could place her life or health in danger.

The other factor raised by the lower Court was testimony elicited from P.M. In answer to a question as to her feelings before the procedure, P.M. replied "[s]cared, but nothing else." (J.S. 10a). This out-of-context remark is not probative of the medical necessity issue. It is ambiguous at best. The fact that P.M. was scared about having an abortion has no negative relevance to a claim that if refused as a patient she may have placed her own life or health in danger. In any event, the proper inquiry was whether the doctor's judgment as to medical necessity had a reasonable foundation. The question is whether her condition and behavior were consistent with a medical necessity prognosis. On this issue the Commonwealth submitted no evidence. Reversal is therefore required under the "no evidence" rule of *Vachon* v. *New Hampshire*, 414 U.S. 478 (1974) (per curiam).[28]

Even if the factors relied on by the Virginia Court amount to the modicum necessary to survive the "no evidence" rule, they do not prove lack of medical necessity beyond a reasonable doubt as required by *In re Winship*, 397 U.S. 358 (1970), and

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[27] Defendant may correctly claim surprise at this appellate finding. It deprives him of the opportunity to defend against a prosecution charge that was never made.

[28] *See also Thompson* v. *Louisville*, 362 U.S. 199 (1960).

Jackson v. *Virginia*, 443 U.S. 307 (1979). Dr. Simopoulos' testimony regarding medical necessity was not disputed. His good faith judgment was not questioned. Rebuttal testimony and witnesses were not even offered. Thus, even after reviewing "the evidence in the light most favorable to the prosecution [no] rational trier of fact" could find beyond a reasonable doubt that there was a lack of medical necessity. See *Jackson* v. *Virginia*, 443 U.S. at 319. *Jackson* therefore requires reversal.

2. Lack of evidence of defendant's intent.

Finally, the burden of disproving requisite intent to perform a non-medically necessary abortion was again apparently placed on defendant. No evidence was submitted by the prosecution to support a contention that Dr. Simopoulos intended to perform a non-necessary abortion. There was apparently a presumption of intent to perform a non-necessary abortion. The burden was shifted to the defendant to refute the presumption.[29]

The placing of the burden in this manner is directly contrary to *Sandstrom* v. *Montana*, 442 U.S. 510 (1979). It also violates the presumption of good-faith that our society accords to physicians. *Roe* v. *Wade*, 410 U.S. at 166. The presumption of unlawful intent as to medical necessity also requires a reversal.

II. THE VIRGINIA SUPREME COURT ERRED IN UPHOLDING THE CONVICTION BECAUSE THE PROSECUTION NEGLECTED TO PRESENT EVIDENCE THAT ACTS OF DR. SIMOPOULOS IN FACT *CAUSED* THE DEMISE OF THE FETUS, AND THE SOLE PROSECUTION MEDICAL WITNESS ADMITTED THE LACK OF EVIDENCE.

The conviction must be reversed for failure of the prosecution to show causation beyond a reasonable doubt. *Jackson* v. *Virginia*, 443 U.S. 307, 319 (1979).

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[29] The irrationality in presuming the physician to be acting unlawfully is discussed *supra* at p. 17 & n.24.

P.M. aborted the fetus at about 11 a.m. on Monday, November 12, 1979. (J.A. 208). She had received an instillation of sodium chloride solution in her uterus around noon two days before. (J.A. 207).

The medical examiner's report indicated that the "manner of death" was natural. (J.A. 237). Tests are available which would establish if the death of the fetus was caused by the saline injection or from other causes (J.A. 332-34). However the prosecution undertook no physical, chemical, or other testing to determine if a saline substance caused or contributed to fetal demise.

Virginia Medical Examiner Dr. Wiecking was the sole medical expert witness for the prosecution in this case. He never met or examined P.M., nor did he study her prior medical history. He performed an autopsy on the fetus. (Pf. Ex. 7, J.A. 313-314).

Dr. Wiecking identified the cause of death in his autopsy report as "immaturity." (J.A. 238). He did not dispute the indication on the medical examiner's report that the "manner of death was natural." (J.A. 237). He admitted that "natural" would be the normal notation in the report "when there has been a spontaneous abortion of some kind." (J.A. 238).

Dr. Wiecking acknowledged that agencies other than saline instillation could cause spontaneous abortion. (J.A. 240). He made the following key admission:

> "A. From examination of the body of the fetus itself, I cannot say that saline, to the exclusion of all other instrumentalities, caused this fetus to be expelled, no, sir." (J.A. 240).

The entire direct examination of Dr. Wiecking runs a total of five transcript pages. (Tr. Apr. 15, 1980, pp. 39-43; J.A. 230-236). He was the full case for the Commonwealth's presentation on all medical questions. Aside from a vague reference to unidentified circumstantial evidence (J.A. 239), Dr. Wiecking did not reinotely approach linking the saline instillation with

the death of the fetus. The prosecution never even asked Dr. Wiecking the appropriate hypothetical questions. It abandoned the inquiry.

Accordingly, the indictment should have been dismissed at the close of the prosecution's case. Defense counsel so moved. (J.A. 300). The trial court denied the motion, relying on unspecified circumstantial evidence. (J.A. 307).

The prosecution case could not have survived a motion for directed verdict in a simple civil malpractice proceeding without at least a trace of expert testimony.[30] The state had none here.

This case, however involves serious criminal charges against a defendant who is presumed innocent. *Some* probative evidence of a medical nature must be required of the State.[31] Otherwise causation depends upon lay speculation and suspicion about a question of medical opinion.

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[30] In *Davis* v. *Virginia Ry. Co.*, 361 U.S. 354 (1959), reversing a decision of the Virginia Supreme Court for insufficiency of evidence, this Court required two evidentiary steps necessary to prove a F.E.L.A. medical negligence claim: "evidence as to the recognized standard of the medical community in the particular kind of case, and a showing that the physician in question negligently departed from this standard in his treatment of the plaintiff." Virginia cases have emphasized the absolute necessity for medical testimony to determine if malpractice occurred. *Little* v. *Cross*, 217 Va. 71, 225 S.E.2d 387 (1976); *Reed* v. *Church*, 175 Va. 284, 8 S.E.2d 285 (1940); *Hunter* v. *Burroughs*, 123 Va. 113, 96 S.E. 360 (1918).

[31] In poisoning cases, it has been held impermissible to obtain a conviction unless the presence of poison is chemically ascertained. See *Joe* v. *State*, 6 Fla. 591, 65 Am. Dec. 579 (1888). In a Virginia case, a criminal conviction was reversed where the prosecution failed to present sufficient expert testimony that the deceased came to his death by poison. Medical witnesses could only testify on the grounds of circumstantial evidence; they *supposed* the victim died from drinking strychnine. There was no chemical analysis of the bottle allegedly containing the poison nor was an autopsy performed on the deceased.

Proof of causation would have required some evidence produced by the Commonwealth of the type of saline solution instilled, the amount needed to cause an abortion, that the fetus had vital signs before the instillation, an examination of the fetus to show whether a saline injection caused its demise, and an absence of reasonably possible intervening causes. No evidence was produced on these issues.

Rather the Court relied totally upon evidence of Dr. Simopoulos' intent to perform an abortion (elicited after the motions for directed verdict and therefore improperly considered) and a statement he had purportedly made to P.M. immediately after injecting the saline solution in which he allegedly told her "the fetus was destroyed." This statement, a comment made to comfort and assure a patient, is not proof of causation in a criminal case. It is at best a prediction of possible events in 12-48 hours.

This evidence can only be speculative since: 1) no proof establishes that Dr. Simopoulos believed that a saline operation could, even if effective, succeed immediately, and 2) all medical witnesses testified that saline is not effective in every instance. Indeed if the statement "the fetus was destroyed" is to be taken as fact at the time uttered then it is conclusive that factors other than the saline injection were the cause of final demise.[32]

Accordingly, the lower court's conviction was set aside for want of medical proof. *Hatchett* v. *Commonwealth*, 76 Va. 1026 (1888). See also *Wilson* v. *State*, 41 Tex.Cr.App. 179, 153 S.W. 122 (1899). In *Wilson* there was evidence that the defendant attempted to abort the decedent. Despite the fact the victim died as a result of injuries consistent with the attempted abortion, a reversal was required on the grounds the prosecution failed to conclusively establish the victim's death was not a result of natural causes.

[32] That the demise of the fetus was due to causes other than saline is consistent with other information in the Record. For example, there is no evidence that the fetus had vital signs. Dr. Wiecking admitted that the fetus had not been viable and had been born dead. (J.A. 232,

In any event this total sum of evidence was certainly insufficient to convince a reasonable trier of fact beyond a reasonable doubt of the existence of every element of the offense. *Jackson* v. *Virginia*, 443 U.S. 307, 316 (1979). Thus, reversal is required.

As a last resort, the Virginia Supreme Court attempted to support a finding of causation on a lack of "evidence of any other causative factor . . ." (J.S. 11a) That wrongly shifted to the defendant responsibility for the prosecution's failure of proof. The shifting of proof on what is undeniably an element of the offense violates due process. E.g., *Patterson* v. *New York*, 432 U.S. 197 (1977). The Commonwealth with all its resources and equipment had full access to the means of proof and disproof. State physicians had the fetus and could have conducted tests to determine if and when a saline solution caused fetal demise.

Dr. Simopoulos had no access to the full means of proof on the causation question. The prosecution would not disclose the name of P.M.'s boyfriend who was familiar with her circumstances and spent some time at the motel. Nor would the prosecution disclose the name of the physician to whom they directed P.M. after the abortion although the physician would have had relevant medical findings.

Despite these burdens, defendant presented uncontradicted evidence belying causation. At least three experts testified that saline injection does not always cause a patient to abort the fetus. (J.A. 332) (Dr. Soyster); (J.A. 240) (Dr. Wiecking); (J.A. 32) (Dr. Schulman). Dr. Schulman explained that it is medically possible after saline is injected that some other factor causes the patient to abort. (J.A. 32). He stated that drugs or medications could cause the patient to abort under those circumstances. *Id.*

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233). Moreover, the medical examiner's report stated the manner of death was natural. The autopsy described the appearance of the fetus as normal. A fetus destroyed by saline on the other hand, usually evidences marked dehydration. (J.A. 322).

Moreover, the spontaneous abortion rate among teenagers in the United States is by no means insignificant. "One in ten teenage girls becomes pregnant each year, resulting in more than 1 million pregnancies, more than 600,000 births, and more than 330,000 induced and 150,000 spontaneous abortions." Klein, *Antecedents of Teenage Pregnancy*, 21 CLINICAL OBST. & GYN. 1151 (1978). P.M. could have been progressing toward one of those 150,000 miscarriages during the 16 weeks she waited before seeing Dr. Simopoulos.

No rebuttal evidence was offered by the Commonwealth. The trial court and the Supreme Court of Virginia were constitutionally required to dismiss the indictment for want of proof of causation.[33]

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[33] In several similar non-abortion cases the Virginia high court has found a failure of proof on causation. E.g., *Christian* v. *Commonwealth*, 221 Va. 1078, 277 S.E.2d 205 (1981) (circumstantial evidence indicating defendant caused bodily harm to her child, not sufficient to sustain a criminal conviction); *Terry* v. *Commonwealth*, 171 Va. 505, 198 S.E. 911 (1938) (death two days after accident not sufficient to establish death resulted from injury); *Lane* v. *Commonwealth*, 219 Va. 509, 248 S.E.2d 781 (1978).

In *Lane*, the Virginia Supreme Court reversed an involuntary manslaughter conviction on the grounds that there was insufficient evidence to show the cause of a child's death. The defendant gave birth without previously knowing she was pregnant. The mother purportedly thinking the child was not born alive, wrapped the child in a towel and placed it in a closed bag. Lengthy medical testimony established that the child was born alive and that death resulted from lack of oxygen. However, no medical witness could state the cause of death with any reasonable degree of certainty. Thus, the court reasoned, a verdict concluding defendant's actions were the cause of death would amount to pure speculation and surmise.

III. THE *MANDATORY HOSPITALIZATION* REQUIREMENT OF THE VIRGINIA ABORTION LAW ABRIDGES THE RIGHTS OF PRIVACY AND DUE PROCESS BY UNDULY RESTRICTING ACCESS TO SECOND TRIMESTER ABORTIONS, CRIMINALIZING SAFE NON-HOSPITAL PRACTICE, AND DELEGATING TO HOSPITALS THE AUTHORITY TO BAN SUCH ABORTIONS ALTOGETHER.

The Virginia statute, as construed below, requires that "the method chosen[34] to initiate a second trimester abortion be performed in a hospital." (J.S. 17a). Under this construction, instillation of saline solution in the operating room of a well-equipped clinic violates the hospitalization element[35] of the statute,[36] and subjects the physician to a potential felony sanction of ten years in prison and mandatory license revocation. VA. CODE §§ 18.2-10(d), 54.321.2.

The Supreme Court of Virginia reasoned that such a statutory requirement was constitutional. (J.S. 17a-19a).[37] That deci-

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[34] The statute does not distinguish among the several medical/surgical techniques used to initiate or perform a second trimester abortion.

[35] Apparently this would be the case even if the patient had gone to the hospital to abort.

[36] The second trimester hospital requirement is also squarely involved in No. 81-1172, *Akron Center for Reproductive Health* v. *City of Akron*, and No. 81-1623, *Ashcroft* v. *Planned Parenthood*.

[37] The Virginia Supreme Court identified only one legislative goal in the statute—regulation of maternal health. (J.S. 18a). The Commonwealth *Motion to Dismiss* filed in this Court asserted the same purpose. *Id.* at 8-9.

Virginia's first restrictive abortion law dates back to 1848. Va. Acts, Tit. II, c.3, sec. 9. The 1919 codification was changed in 1960. *Compare* VA. CODE § 4401 (1919), *with* VA. CODE § 18.1-62, 1960 Va. Acts c.358.

1970 marked the first substantial revision since 1848. At that time Virginia adopted a variation of the Model Penal Code, VA. CODE ANN.

sion disregards the severe burden on the right of privacy. It slights the overwhelming evidence that maternal health is not enhanced by the challenged restriction. The conclusion altogether fails to show that the mandatory hospital monopoly is a narrowly drawn restraint necessary to satisfy a compelling state interest.

This Court has discussed aspects of second trimester abortion in four prior cases.[28] *Colautti* v. *Franklin*, 439 U.S. 379 (1979), and *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976), in particular, held certain state law restrictions unconstitutional[39] that involved midtrimester

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§ 18.1-62 (Supp. 1972), including for the first time a mandatory hospitalization requirement, a hospital review board of at least three physicians, spousal consent, and parental consent.

At least five of the Virginia restrictions of 1970 were unconstitutional under *Roe* v. *Wade* and *Doe* v. *Bolton*, *supra*. In 1975 *Bigelow* v. *Commonwealth*, 421 U.S. 809 (1975), struck down a further broad restriction on the advertising of abortion services.

The present statute was approved February 14, 1975, over two years after *Roe* v. *Wade*.

[38] *Roe* v. *Wade*, 410 U.S. 113 (1973), and *Doe* v. *Bolton*, 410 U.S. 179 (1973), struck down prohibitions that affected all stages of pregnancy. No provision of the Texas or Georgia law focussed solely on the second trimester. Medical experience with midtrimester abortion techniques was gained primarily between 1970 and the present.

The record in this case is the first before the Court on need for outpatient second trimester abortions, the safety of alternative facilities other than hospitals, and the abdication of hospitals from serving the more than 100,000 patients annually who choose to end an unwanted pregnancy after the first trimester. *See Center for Disease Control: Abortion Surveillance 1978* iv, 1 (Nov. 1980) (1.16 million abortions in 1978 total); Henshaw, *Abortion Services in the United States, 1979 and 1980* (ADDENDUM 5).

[39] *Colautti* described the midtrimester procedure and noted evidence that "saline amnioinfusion was the method of choice." 439 U.S. at 398 & n.18. The statute in question involved "the choice of abortion procedures." *Id.* at 400. This Court held the statute void for vagueness. *Id.* at 401.

saline instillation procedures.[40] The Court has not, however, decided whether a state may criminalize nonhospital abortions performed in safe facilities after the first trimester, where the burden of denying such patients their privacy rights is severe,[41] and in-hospital availability is very limited. The *Gary-Northwest* memorandum decision could not have reached this issue for the reasons set out more fully in the Jurisdictional Statement[42] of this appeal.

Burden Of The Right Of Privacy

The criminalization of all non-hospital second trimester abortions in Virginia works a severe hardship on the fun-

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[40] *Danforth* has an extensive discussion on the safety and prevalence "of saline amniocentesis as an accepted medical procedure in this country . . ." 428 U.S. at 77. The Court held a ban on saline procedures unconstitutional. 428 U.S. at 79.

[41] Dr. Simopoulos' fundamental interests are also burdened by this prosecution. He has standing to assert the right of privacy of the patient whose interests were invaded by this prosecution. *Colautti* v. *Franklin*, 439 U.S. 379, 383 n.3 (1979); *Carey* v. *Population Services International*, 431 U.S. 678, 686 (1977); *Eisenstadt* v. *Baird*, 405 U.S. 438, 445 (1972); *Griswold* v. *Connecticut*, 381 U.S. 479, 481 (1965). This result is consistent with the majority, concurring, and dissenting opinions in *Singleton* v. *Wulff*, 428 U.S. 106, 128 (1976) (Powell, J., separate opinion).

[42] J.S. 15-17. *Gary-Northwest* was an attempt to reopen a denial five years earlier of a preliminary injunction against a different type of statutory hospital requirement. The summary affirmance there could rest on the conclusion that there was no abuse of discretion as to any one of several possible grounds of decision. There was never a trial on the merits in *Gary-Northwest* v. *Orr*, 496 F. Supp. 894 (N.D. Ind. 1980) (three-judge court), *aff'd mem.*, 451 U.S. 934 (1981). On the limited effect of such a summary affirmance, see *Metromedia, Inc.* v. *San Diego*, 452 U.S. 490 (1981); *Illinois State Bd. of Elections* v. *Socialist Workers Party*, 440 U.S. 173, 182-83 (1979); *Mandel* v. *Bradley*, 432 U.S. 173, 176 (1977); *see also University of Texas* v. *Camenisch*, 451 U.S. 390, 395 (1981) (preliminary injunction not a decision on merits).

damental right recognized in *Roe* v. *Wade*, *supra*. That burden is not absolute, but it is arduous and significant to substantial numbers of women and physicians.[43]

The specified northern Virginia area has "sixteen or seventeen hospitals." (J.A. 128). The entire State has 95 hospitals.[44] Only two of the northern Virginia hospitals permit second trimester abortion. Both require parental consent for minors. (J.A. 134, 202, 97-98, 148-49, 327-28, 391, Df. Ex. 7). That constitutes about 12% (2/16) of the available hospital facilities in the area for adults, but 0% for a young woman under age 18.[45] Even if a minor reviewed the extensive documentation in this Record, she could not find a place for a second trimester abortion unless she had parental consent and substantial funds.

There is no evidence at all in the Record of any alternative facility reasonably accessible to P.M.[46] Cities such as Rich-

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[43] The impact on this particular litigant and the patient P.M. has been most severe. The doctor is branded a felon. The young woman's privacy and anonymity are invaded by the arrival of four law enforcement officers on her doorstep. (J.A. 287). She ultimately had to appear in a public courtroom three times to testify against the physician who tried to help her. (J.A. 176, 188, 263). The Commonwealth made it impossible "to protect the very privacy of her decision from the publicity of a court suit." *Singleton* v. *Wulff*, 428 U.S. 106, 117 (1976).

[44] *Abortion: Need, Services and Policies, Virginia*, 1 (A.G.I. 1979) (ADDENDUM 17).

[45] If P.M. was 22 weeks LMP pregnant on November 10, 1979, then she would have been 28 weeks pregnant on her 18th birthday December 21. (J.A. 176). Her circumstances vividly illustrate the truth of the statement that "an unwanted pregnancy is probably more of a crises for a minor than for an adult, because the abortion decision cannot be postponed until her majority . . ." *H.L.* v. *Matheson*, 450 U.S. 398, 436 (1981) (Marshall, J., dissenting).

[46] One study on Virginia abortion services found that "[f]orty-six percent of women in need were unable to obtain services in Virginia. . . . The majority of the abortions in the state in 1977 (77 per-

mond, Norfolk, and Lynchburg are a substantial distance away for a journey to obtain medical care.[47] The national experience is well-documented and supports a similar conclusion:[48] the right of privacy in the second trimester is burdened when non-hospital clinics are outlawed.[49]

Burden On Health

Each woman who is denied access to a second trimester abortion in Virginia loses much more than "the interest in independence in making certain kinds of important decisions." *Whalen* v. *Roe*, 429 U.S. 589, 599-600 (1977) (Stevens, J.). She faces a risk to her health that may be large or small, depending on her remaining alternatives.

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cent) were performed in 15 nonhospital clinics and physicians' offices; [only] 24 percent occurred in hospitals. . . ." *Abortion: Need, Services and Policies, Virginia*, 1, 2 (A.G.I. 1979) (ADDENDUM 16, 17).

[47] *Id.* (ADDENDUM 16). "Some of these women had to travel long distances to obtain abortion services . . ."

[48] Published studies in the Addendum lodged with the Court examine the availability of abortion services throughout the United States. *See* ADDENDUM, Documents #2, #9, #10, #13, at 5, 57, 60, 80.

[49] Significant national findings include the following:

"Almost 80 percent of all abortions were performed in nonhospital facilities in 1980. . . . The proportion performed in hospitals dropped from a high of 52 percent in 1973 to just 22 percent in 1980. . . . [I]mprovements in and simplifications of the technology . . . have made services in freestanding facilities an increasingly practical and suitable option, far less costly than hospital-based services. . . . [O]nly 24 percent [of abortion providers] perform abortions after 14 weeks. . . ." Henshaw, *Abortion Services in the United States, 1979 and 1980* (ADDENDUM 5).

The Henshaw study concludes:

"There is abundant evidence that many women still find abortion services difficult or impossible to get because of the distance they live from the nearest provider, the cost, a lack of information . . . and other restrictions." *Id.* at 7.

The Virginia *Vital Statistics for 1979* noted "[o]ne or more complications of pregnancy . . . [for] 26.1 percent of mothers having live births." *Id.* at 17.

Justice Rehnquist has catalogued from the literature the "significant social, medical, and economic consequences . . ." of teenage pregnancies.[50] *Michael M.* v. *Superior Court of Sonoma County*, 450 U.S. 464, 470 (1981). These include key facts that show the burden on health of legal restrictions in access to abortion:

> "The risk of maternal death is 60% higher for a teenager under the age of 15 than for a woman in her early twenties. The risk is 13% higher for 15-to-19 year olds. The statistics further show that most teenage mothers drop out of school and face a bleak economic future. (citations omitted)." 450 U.S. at 470 n.4.

In sum, the ban on non-hospital second trimester abortions substantially limits available facilities. At least "15 nonhospital clinics" in Virginia are affected. (ADDENDUM 17). Women are restricted in their choices and forced to choose among other alternatives with varying health hazards.

Burden Of Travel

P.M., a minor, or any adult woman in a community with no available hospital, could theoretically journey to another city, state, or country for a second trimester abortion. The Supreme Court of Virginia, in fact, justified its decision by insisting that

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[50] This Court in *Carey* referenced the "frequently devastating" consequences of an unplanned pregnancy:

> "'Teenage motherhood involves a host of problems, including adverse physical and psychological effects upon the minor and her baby, the continuous stigma associated with unwed motherhood, the need to drop out of school with the accompanying impairment of educational opportunities, and other dislocations [including] forced marriage of immature couples'. . . ." 431 U.S. at 696 n.21.

"two hospitals in Northern Virginia and 24 hospitals located elsewhere[51] in the State were providing abortion services in 1977." (J.S. 19a). That general statement, however, does not begin to address the second trimester hospital access problem caused by the statute. The two (out of sixteen) northern Virginia hospitals which allowed *second* trimester abortions also required parental consent. (J.A. 97-98, 134, 202, 148-49, 328, 391, Df. Ex. 7). Hospitals elsewhere in Virginia or in D.C. may or may not have allowed second trimester abortions without parental consent. Assuming one available hospital somewhere in Virginia, P.M. faced a significant burden of travel, expense, and even more unexplained absence from home. This burden would not be a factor if she could legally have an outpatient abortion nearby. The statute made that option unlawful.

A travel burden was considered significant by this Court in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 77 n.12 (1976). There the saline type of abortion procedure was banned in Missouri. Alternatives were inaccessible.[52] Here all non-hospital second trimester procedures are banned. The burdens imposed differ only in degree.[53]

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[51] There is certainly no evidence that those 24 hospitals are nearby, accessible, and offer second trimester abortions. *Compare Schad* v. *Borough of Mt. Ephraim*, 452 U.S. 61, 76 (1981):

> "[T]here is no evidence in this record . . . [of availability] in reasonably nearby areas."

[52] Justice Blackmun stated for the Court: "[L]imited use of prostaglandin throughout the country does not make it available or accessible to concerned persons in Missouri." 428 U.S. at 77 n.12. *Compare Mississippi Univ. for Women* v. *Hogan*, ___ U.S. ___, ___ n.8 (1982) (". . . [He] could only attend by driving a considerable distance from his home.")

[53] A substantial majority of the second trimester abortions done in Virginia are by instillation. Virginia *Vital Statistics for 1979* reports that "[i]ntra-uterine saline instillation and intra-uterine prostaglandin instillation were the methods used for 503, or 78.7 percent, of the 639 pregnancy terminations of 18 weeks or more gestation." *Id.* at 25.

Standard Of Review

"[T]he standard of review is determined by the nature of the right assertedly threatened or violated . . ." *Schad* v. *Borough of Mt. Ephraim*, 452 U.S. 61, 68 (1981).

Restrictions on available facilities for abortion impact the right of privacy at least as severely as regulatory limits on mail order contraceptive vendors.[54] Both "clearly burden the freedom to make such decisions" as "whether to bear or beget a child." *Carey* v. *Population Services International*, 431 U.S. 678, 687 (1977).

In the related areas of privacy and contraception this Court has used a single "compelling interest" standard for all types of restrictions.[55]

> " 'Compelling' is of course the key word; where a decision as fundamental as that whether to bear or beget a child is involved, regulations imposing a burden on it may be justified only by compelling state interests, and must be narrowly drawn to express only those interests." *Carey* v. *Population Service International*, 431 U.S. 678, 686 (1977).

This standard is complemented by the principle recently stated in *Harris* v. *McRae*, 448 U.S. 297, 312 (1980):

> "It is well settled that, quite apart from the guarantee of equal protection, if a law 'impinges upon a fundamental

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[54] The majority in *Carey* compared the hospital limitation from *Doe* v. *Bolton*, 410 U.S. 179, 193-95 (1973), with the medical restrictions on contraceptives in *Carey*. 431 U.S. at 689.

Even a "zoning law [which] infringes upon a protected liberty . . . must be narrowly drawn and must further a sufficiently substantial government interest." *Schad* v. *Borough of Mt. Ephraim*, 452 U.S. 61, 68 (1981).

[55] The "compelling interest" standard is particularly applicable here because a criminal statute penalizing an acceptable medical practice involves "direct and substantial interference with constitutionally protected rights." *Carey* v. *Population Services International*, 431 U.S. 678, 703-04 (1977) (Powell, J., concurring).

> right explicitly or implicitly secured by the Constitution [it] is presumptively unconstitutional.' "

The Virginia Supreme Court applied an erroneous standard of review. It relied upon

> "A presumption of constitutionality . . . (The) burden rests upon those who question their validity to overcome the presumption." (J.S. 19a).

The test of *Carey*, derived from *Roe* v. *Wade*, 410 U.S. 113, 155 (1973), was controlling, however, and should not have been disregarded below. *Roe* and the decisions applying it are "now part of our law. . . ."[56]

The *Brief for the United States* filed July 29, 1982, by the present Solicitor General in two related cases[57] addresses the standard of review applicable to abortion cases.[58]

In the present case there is a substantial showing of "undue burden" sufficient to invoke the strictest standard of review from any decision relied upon by the Solicitor General. E.g., *Carey*, *supra*.[59] To the extent that the brief is a plea for judicial

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[56] *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 101 (1976) (Stevens, J., concurring); *Harris* v. *McRae*, 448 U.S. 297, 350 (1980) (Stevens, J., dissenting).

[57] No. 81-746, *City of Akron* v. *Akron Center for Reproductive Health*, and 81-1623, *Ashcroft* v. *Planned Parenthood*.

[58] In earlier cases involving abortion no Solicitor General has taken a position unless directly involved in litigation over a federal law. E.g., *Harris* v. *McRae*, 448 U.S. 297 (1980). The administration for the United States filed no briefs in *Roe* v. *Wade*, 410 U.S. 113, 115 n.* (1973); *Doe* v. *Bolton*, 410 U.S. 179, 181 n.* (1973); *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 55 n.* (1976); *Colautti* v. *Franklin*, 439 U.S. 379, 380 n.* (1979); nor *H.L.* v. *Matheson*, 450 U.S. 398, 399 n.* (1981).

[59] This case does not involve *government* funding of abortion services. Nor does it concern the rights of parents of a minor. Accordingly, the Solicitor General's heavy reliance on *Maher* v. *Roe*, 432 U.S. 464 (1977), *Bellotti* v. *Baird*, 443 U.S. 622 (1979) (*Bellotti II*), and related cases, is misplaced in this context. *See Brief for the United States*, *supra*.

abdication in this controversial, highly politicized area, such deference by the Court in a sphere of sensitive constitutional liberties would be inconsistent with "the institution itself, its unique responsibility under our system, and its tradition of independence. . . ." Powell, *Of Politics and the Court*, 1982 YEARBOOK: SUPREME COURT HISTORICAL SOCIETY 23, 26.

The *Roe-Carey* "compelling interest," "narrowly drawn," standard of review has been a workable guide for the lower courts. There have been no drastic differences in the application of the tests in the Fourth,[60] Fifth,[61] Sixth,[62] Seventh[63] and Eighth[64] Circuits.[65]

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[60] See *Doe* v. *Charleston Area Medical Center, Inc.*, 529 F.2d 638, 644 (4th Cir. 1975) (hospital ban on abortions held unconstitutional).

[61] See *Poe* v. *Gerstein*, 517 F.2d 787, 791 (5th Cir. 1975), *aff'd per curiam*, 428 U.S. 901 (1976); *Deerfield Medical Center* v. *City of Deerfield Beach*, 661 F.2d 328, 336 (5th Cir. 1981) (zoning restriction on abortion clinic unconstitutional).

[62] See *Akron Center for Reproductive Health* v. *City of Akron*, 651 F.2d 1198 (6th Cir. 1981), cert. granted, ___ U.S. ___ (1982); *Mahoning Women's Center* v. *Hunter*, 610 F.2d 456, 460 (6th Cir. 1979), vacated on other grounds, 447 U.S. 918 (1980).

[63] See *Charles* v. *Carey*, 627 F.2d 772, 776 (7th Cir. 1980) (preliminary injunction against provisions of Illinois abortion act).

[64] See *Planned Parenthood Association of Kansas City Missouri* v. *Ashcroft*, 664 F.2d 687, 690 n.6 (8th Cir. 1981), cert. granted, ___ U.S. ___ (1982).

[65] But cf. *Baird* v. *Department of Public Health*, 559 F.2d 1098, 1101 (1st Cir. 1979) (restrictive general clinic regulations upheld in first trimester).

Any substantial departure from the traditional standard of review would cast doubt over the authority of well over a hundred lower court decisions.[66] A change would invite a new round of state and local legislation, followed by litigation, to test the limits of the new standard as applied to any novel restriction that could muster a majority of a given city council.

No Compelling Interest

The legitimacy of a state interest in maternal health is beyond question, both generally and in the context of abortion.[67] Indeed, the entire professional career of Dr. Simopoulos has been directed to providing maternal health care. The questions here are (1) whether the state has a *compelling interest* in imposing criminal penalties on the performance of safe non-hospital abortions in the second trimester, and (2)

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[66] Unappealed district court, state court, and appellate decisions are commonplace on abortion-related issues such as clinic regulations, zoning, hospital access, waiting periods, funding, transfer agreements, facility licensing, third party notice, viability, and even the retroactivity of *Roe* v. *Wade*, 410 U.S. 113 (1973). A five volume *Abortion Law Reporter* published by Antioch School of Law contains the overwhelming majority of the cases. Citations to *Roe* and *Doe* in the eight columned Shepard's already exceed three full pages, approximately one thousand eight hundred entries.

Roe and *Doe*, of course, have been cited not only for the standard of review but also on questions of standing, ripeness, mootness, class actions, party anonymity, abstention, judicial notice, privacy in general, and the scholarly history of the Hippocratic Oath. Nonetheless, a vast number of well reasoned decisions depend upon the *Roe* standard of review for their essential authority as valid law.

[67] In Virginia abortions may only be performed by licensed medical physicians. VA. CODE § 18.2-71. Any abortion by a non-physician is a felony. Childbirth is treated differently. Special licenses to assist in childbirth are available for nurse midwives. VA. CODE §§ 32.1-145 *et. seq.*

whether criminal penalties to enforce total hospitalization are a *narrowly drawn* requirement.

Roe v. *Wade*, 410 U.S. 113 (1973), found in 1973 that the " 'compelling' point, in the light of present medical knowledge, is at approximately the end of the first trimester." 410 U.S. at 163; *Id.* at 149. This finding derived from the consequences of "[m]odern medical techniques. . . ." *Id.* Advances in medical care had made maternal mortality for early abortions "as low as or lower than the rates for normal childbirth." *Id.* Accordingly,

> "any interest of the State in protecting the woman from an inherently hazardous procedure, except when it would be equally dangerous for her to forgo it, has largely disappeared." *Id.*

The comparison with childbirth was logical, had solid scientific underpinnings,[68] and was similar to the text in the 1967 British law inserted "at the request of the Lord Chief Justice . . . to enable the judges to define the element of risk that would justify abortion."[69] The scientific basis of the comparison

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[68] The Court relied on a number of authoritative studies cited in 410 U.S. at 149 n.44.

[69] Simms, *The Evolution of Abortion and Sterilization Legislation in the United Kingdom*, in ABORTION AND STERILIZATION 57, 66 (J. Hodgson ed. 1980).

The British *Abortion Act of 1967* has permitted both first and second trimester abortions in special non-hospital facilities known as "private nursing homes." *Id.* These must be approved by the "Minister of Health or the Secretary of State under the National Health Services Acts . . ." *Abortion Act 1967*, s.1(3). They are necessary because "only 50% [of the abortions] are undertaken in NHS hospitals." I. Craft, *Abortion Update in Great Britain*, in PREGNANCY TERMINATION: PROCEDURES, SAFETY, AND NEW DEVELOPMENTS 380, 386 (G. Zatuchni ed. 1979) (proceedings of international postgraduate conference).

was reaffirmed in a 1982 study published by the Journal of the American Medical Association which concluded:

> "[B]etween 1972 and 1978, women were about seven times more likely to die from childbirth than from legal abortion, with the gap increasing in the more recent years." Lebott, *Mortality From Abortion and Childbirth* (ADDENDUM 1).

Roe did far more than protect the right of privacy and legalize abortion after a century of legislative inaction. The decision is directly responsible for vast improvements in American maternal life and health over the last decade.[70] Moreover, *Roe* led to medical/surgical advances in outpatient treatment that have widespread international application in all other spheres of minor surgery.[71]

Roe was carefully reasoned to protect women from any "inherently hazardous procedure . . ." 410 U.S. at 149. Clearly no such procedure is involved here. Both the trial evidence and the secondary authorities[72] show, as *Danforth* found, that saline instillation "is safer, with respect to maternal mortality, than even continuation of the pregnancy until normal child-

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[70] Maternal mortality dropped from 15.2/100,000 in 1972 to 8.0 in 1978. Legal abortion mortality dropped from 4.1/100,000 to 0.5 over the same time. Lebolt, Tables 1 & 2 (ADDENDUM 2).

[71] Nearly 80% of 1.55 million legal abortions were performed in nonhospital facilities in 1980 in the United States. Henshaw, *Abortion Services in the United States, 1979 and 1980* (ADDENDUM 5). This experience has direct application to ambulatory surgical care in other fields.

[72] The Addendum includes six medical publications from the professional literature on midtrimester abortion techniques and safety. Four of the studies deal specifically with outpatient saline abortion. (ADDENDUM Documents #4, #5, #7, #8, at 18, 24, 35, 51).

Document #11 (ADDENDUM 67) provides a basis for comparing the safety of abortion techniques with over 200 different operative procedures. Appendectomy, for example is reported to have a mortality rate of 230/100,000 procedures. (ADDENDUM 72).

birth." 428 U.S. at 78. That finding, made at a trial in 1974, is even more valid eight years later in 1982.

The expert testimony in the instant case is in accord. For example, Dr. Schulman, a leading national expert, agreed with this Court's statement that saline instillation

> "is safer with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth." (J.A. 29).

A local gynecologist, Dr. Gresinger, regarded Dr. Schulman's findings as authoritative. (J.A. 150). Dr. Gresinger testified that these results reflected his own experience with midtrimester saline abortions, except that he found an even lower complication rate. (J.A. 150-151).[73]

The Court recognized the medical acceptability of saline amniocentesis in *Danforth*, 428 U.S. at 77. It did so again in *Colautti* v. *Franklin*, 439 U.S. at 397-98. The Court there

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[73] The most recent comprehensive textbook on abortion and sterilization also specifically repeated this key question:

> " 'Are second trimester abortions safer than letting the patient continue to term for the delivery?' The discussion was thoughtful and some of the replies were qualified. Yet the majority of experts answered it in the affirmative."

T. Kerenyi, *Intraamniotic Techniques*, in ABORTION AND STERILIZATION 359, 366 (J. Hodgson ed. 1980). The author, Dr. Kerenyi, a professor at Mt. Sinai Hospital in New York, compared an instillation mortality rate of 6.5 per 100,000 patients with a general maternal mortality (excluding induced abortions) of 20 per 100,000. This accords with a more recent textbook publication by Dr. Schulman that states: "The 1972 to 1977 death-to-case ratio was 12.2 for instillation methods but dropped to 6.5 per 100,000 in 1977." Schulman, *Second Trimester Abortion: Techniques and Complications*, in 6 GYNECOLOGY AND OBSTETRICS c.60, at 10 (J. Sciarra ed. 1982) (six volume textbook treatise). For young women in the 15-19 year age group the maternal mortality rate has been reported as 11.3/100,000. See 11 MILLION TEENAGERS 23, 62, Figure 17 (1976).

pointed to expert testimony that "saline amnio-infusion [instillation] was the method of choice" at this stage of pregnancy. *Id.* at 398.

The reasoning in *Danforth*, the underlying test in *Roe*, the observations in *Colautti*, the testimony of highly respected local and national experts, and the findings in recognized professional publications all show that midtrimester saline instillation procedures are safer than childbirth, and clearly not inherently dangerous or substantially hazardous. It follows from *Roe* and *Danforth* that the state lacks a compelling interest in criminalizing the procedure. Such a prohibition "fails as a reasonable regulation for the protection of maternal health," and is unconstitutional under *Roe* and *Danforth*, 410 U.S. at 78-79.[74]

The severe burden on the right of privacy is sufficient in itself to invalidate the Virginia statute where, as here, there is no compelling state interest. See *Standard of Review, supra.* In the alternative, however, the statute is unconstitutional for the additional reason that it is not narrowly drawn to effectuate the legitimate health interest.

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[74] The Record in this case concerned the principal second trimester technique used in Virginia, *i.e.*, saline instillation. The Record was not developed in any depth as to the D & E procedure. Similarly, the saline procedure was not represented in the companion cases to this appeal. The literature shows an increasing use of outpatient D & E procedures in the second trimester in many states, although not Virginia. For example, one recent study involved 1,000 second trimester patients safely treated at "a small, private outpatient abortion facility located across the street from a community hospital." Hern, *Outpatient Second-Trimester D & E Abortion through 24 Menstrual Weeks' Gestation*, 16 ADVANCES IN PLANNED PARENTHOOD 7 (1981).

Overbreadth Of The Hospital Requirement[75]

As construed, the Virginia statute requires only that "the method chosen *to initiate* a second trimester abortion be performed in a hospital." (J.S. 17a) (emphasis added). After the saline is instilled, the patient may go anywhere she chooses without affecting the physician's criminal culpability. She may walk across the street to a hospital, but that is no defense.

Experts at the trial of Dr. Simopoulos uniformly testified that performance of saline instillation in a non-hospital facility was medically acceptable (J.A. 20, 96, 148, 327). One of the experts, Dr. Schulman, had published a study on outpatient saline instillation. (ADDENDUM 18). This article, *Outpatient Saline Abortion*, was introduced into evidence as Defendant's Exhibit 9.

Dr. Schulman reported that outpatient saline instillation was highly successful. Patients underwent the instillation procedure in an "office or treatment room environment." (ADDENDUM 23). The patients were then permitted to return home to await the "onset of abortion." (ADDENDUM 18). About 70 percent of the patients chose to abort at home. (ADDENDUM 22). Morbidity for these outpatient instilla-

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[75] The institution of the "hospital" has a special place in American culture. It is a refuge of safety for the sick where opportunity for health and recovery is present. Without disturbing that vision, the record in this case simply shows that one particularly fundamental procedure is relatively inaccessible and may safely be performed elsewhere. This leaves the full hospital facilities for patients who are more critically ill and usually more welcome in a hospital.

Appellant's position may be seen as supporting the concept of safe, low cost ambulatory health care for patients who do not need to be hospitalized. This is one of the principal objectives of the *National Health Planning and Development Act*, 42 U.S.C. § 300 k (a) (4) (". . . the substitution of ambulatory . . . for inpatient hospital care.").

tions and abortions was "equal to or less than that for abortions administered on an inpatient basis." (ADDENDUM 28).

The medical experts also testified at trial that Dr. Simopoulos' facility was an appropriate setting for an instillation procedure. Three had actually inspected the facility. (J.A. 19-22, 96, 148, 324-326). The experts saw no need for a mandatory hospital requirement. As discussed previously, the Commonwealth did not rebut this testimony. Ali of the resources of the State were unable to muster a single serious contrary witness.

The procedure used by Dr. Simopoulos, when done in a hospital treatment room, operating room, or other designated place, is not safer by reason of location.[76] It becomes, however, less available, subject to hospital policies if not politics, and much more expensive. The fact that institutionally cautious hospitals allow the procedure to be done in lightly equipped

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[76] The drafters of the MODEL PENAL CODE made the following recommendation with respect to the type of facility:

> "Hospital facilities are overburdened, and in some rural areas inaccessible. It may be assumed that hospitals maintained by some religious groups would not permit abortion under any circumstances. The operation is ordinarily not difficult or dangerous when performed by a competent physician, so that medical considerations alone do not call for hospitalization."

MODEL PENAL CODE § 207.11, Comments, at 157 (Tent. Draft No. 9, 1959).

In 1970, the second tentative draft of the UNIFORM ABORTION ACT (Aug. 1970), stipulated that the procedure could be performed "in a medical clinic, or in a hospital . . ."

treatment rooms (J.A. 326) shows further that hospitalization was never necessary in the first place.[77]

In 1982 the hospital requirement for second trimester abortions[78] is vulnerable to "a mass of data" that is even more

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[77] In the context of health education, rather than medical services, this Court recently reiterated an important point that is relevant here:

> "[We] consistantly have emphasized that 'the mere recitation of a benign, compensatory purpose is not an automatic shield which protects against inquiry into the actual purposes underlying a statutory scheme.' "

Mississippi University for Women v. *Hogan*, ___ U.S. ___ (1982).

The purpose of protecting maternal health in the Virginia statutory scheme is mere recitation, not reality.

Virginia made virtually no change in its 1848 criminal abortion law until 1970 when it introduced five provisions that have since been found unconstitutional. *See* note 38, *supra*. Maternal health needs were never a lawful reason for abortion in Virginia until 1970, and then the abortion decision was surrounded with procedural obstacles at every step. The abortion statute has never been in the health code as a public health regulation. It always has been in the criminal code as the only medical felony.

Virginia had no hospitalization requirement for abortion from 1848 until 1970 and none again from January 22, 1973, until February 14, 1975. The 1975 law criminalizing non-hospital second trimester abortions still carries the 1848 baggage of archaic language about "use [of] any means with intent to destroy her unborn child. . . ." VA. CODE § 18.2-71. There is no legislative history, report, or study which remotely suggests a medical need for the criminal statute in question. The overwhelming majority of states have no such criminal prohibition. (*Roe* cites the statutory provision as of 1973. 410 U.S. at 118 n.2; *Id.* at 139-140 nn.34-37.) At least twenty-seven of these States would not have prosecuted Dr. Simopoulos today.

[78] Virginia has no criminal law requiring childbirth or any other procedure to take place in a hospital although hundreds of medical-surgical procedures have a greater risk of mortality.

persuasive than the demonstration made in 1971 and 1972. *See Doe* v. *Bolton*, 410 U.S. 179, 195 (1973). Here, as in *Doe*,

> "The State . . . has not presented persuasive data to show that only hospitals meet its acknowledged interest in insuring the quality of the operation and the full protection of the patient. . . . [T]he State must show more than it has in order to prove that only the full resource of a licensed hospital, rather than those of some other appropriately licensed institution, satisfy these health interests." 410 U.S. at 195.

Accordingly, the hospital requirement incorporated in the indictment and VA. CODE § 18.2-71 is not narrowly drawn and is unconstitutional.[79]

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[79] This result and the reasoning set out are consistent with the decisions of three lower federal courts and the rationale of another. Those decisions have been reproduced in the Addendum for the convenience of this Court. (ADDENDUM, Documents #14, #15, #16, #18, #19, at 82, 87, 92, 122, 168).

CONCLUSION

For the reasons set out, this Court should reverse the judgment of conviction of Dr. Simopoulos, hold the statute unconstitutional, and direct further proceedings to dismiss the indictment.

Respectfully Submitted:

Counsel of Record
ROY LUCAS
LUCAS & ASSOCIATES, P.C.
Three Ten Constitution Avenue, N.E.
Washington, D.C. 20002
Tel: (202) 543-5115
By: Roy Lucas
ROY LUCAS

WILLIAM P. MARSHALL
1515 Hague Avenue
St. Paul, MN. 55104
Attorneys For Appellant.

Of Counsel:
JOHN H. OBRION
BROWDER, RUSSELL, LITTLE,
MORRIS & BUTCHER
1200 Ross Building
Richmond, VA. 23219

Appellee's Brief

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In The

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October Term, 1982

CHRIS SIMOPOULOS,

Appellant,

v.

COMMONWEALTH OF VIRGINIA,

Appellee.

Appeal From The Supreme Court Of Virginia

BRIEF FOR APPELLEE

GERALD L. BALILES
Attorney General

WILLIAM G. BROADDUS
Chief Deputy Attorney General

THOMAS D. BAGWELL*
JULIA KREBS-MARKRICH
Assistant Attorneys General

Attorneys for Appellee

Supreme Court Building
Richmond, Virginia 23219
(804) 786-2071

**Counsel of Record*

QUESTIONS PRESENTED

1. Whether Virginia law, which does not require the prosecution to affirmatively negate a potential defense which the defendant never invokes, violates Due Process?

2. Whether evidence described by the trial court as "incredibly strong" was sufficient to permit the court to find beyond a reasonable doubt that Simopoulos' administration of a saline amniocentesis on Patricia resulted in the death or expulsion of her fetus?

3. Whether a narrowly drawn hospitalization requirement for second trimester abortions, specifically authorized in 1973 by *Roe* v. *Wade*, 410 U.S. 113, 163, now violates a woman's right to privacy?

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Simopoulos v. *Coleman*, Civil Action No. 82-9476A (E.D. Va. Sept. 29, 1981) *app. removed without prej*, No. 82-1106 (4th Cir. Apr. 15, 1982) 25

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State v. *Bridges*, 412 S.W.2d 455 (Mo. 1967) 10

State v. *Orsini*, 155 Conn. 367, 232 A.2d 907 (1967) 10

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United States v. *Vuitch*, 402 U.S. 62 (1971) 7, 9, 10,11

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Va. Code § 18.2-74 2

Va. Code § 18.2-74.1 2

Va. Code § 18.2-76 2

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Va. Code §§ 54-273—325.15 29

Va. Code § 54-325.2 (D) (2) 2

Regulations

Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) 8, 23

Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1981) 29

Rules and Regulations of the Healing Arts Licensed and Regulated by the Board of Medicine (1982) 29

Other Authorities

Cates,*et al.*, *Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities,* 58 Obstetrics and Gynecology 401 (1981) 27

Cates, *et al.*, *The Risk of Dying from Legal Abortion in the United States, 1972-1975,* 15 Int. J. Gynaecol. Obstet. 172 (1977) 21

Centers for Disease Control: Abortion Surveillance 1978 (Nov. 1980) 20

Grimes, *The Brief for Hypertonic Saline,* 15 Contemporary Ob/Gyn. 29 (1980) 20

Kawada, *Techniques of Second Trimester Abortion,* 20 Clinical Obstetrics and Gynecology 833 (1977) 20, 21, 22, 31

LeBolt, *et al.*, *Mortality from Abortion and Childbirth: Are the Populations Comparable?* 248 Journal of the American Medical Association 188 (1982) 30

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Philip, *et al., Neonatal Mortality Risk for the Eighties: The Importance of Birth Weight/Gestational Age Groups,* 68 Pediatrics 122 (1981) 28

Pritchard and MacDonald, *Williams Obstetrics* (16th ed. 1980) . 27

Pritchard and MacDonald, *Williams Obstetrics* (15th ed. 1976) . 14

Schiffer, *et al., Mortality Associated with Hypertonic Saline Abortion,* 42 Obstetrics and Gynecology 759 (1973) 23

Stroh, *et al., Reported Live Births Following Induced Abortion: Two and One-Half Years' Experience in Upstate New York,* 126 Am.J. Obstet. and Gynecol. 83 (1976) 22

Technical Bulletin of the American College of Obstetricians and Gynecologists No. 37 (Feb. 1976) 21, 22

Technical Bulletin of the American College of Obstetricians and Gynecologists No. 56 (Dec. 1979) 20, 21, 22

Virginia Department of Health, 1978 Statistical Report 20

In The

Supreme Court of the United States

October Term, 1982

No. 81-185

CHRIS SIMOPOULOS,

Appellant,

v.

COMMONWEALTH OF VIRGINIA,

Appellee.

Appeal From The Supreme Court Of Virginia

BRIEF FOR APPELLEE

STATEMENT OF THE CASE

On November 8, 1979, Patricia, an unmarried girl living with her parents, was seventeen years of age, only six weeks short of her eighteenth birthday. (J.A. 263, 432) Patricia was also twenty-two weeks pregnant, only several weeks short of beginning the third trimester of her pregnancy. She wanted an abortion. (J.A. 264)

A.

The Virginia Statutes

In order to appreciate fully the legal implications of the doctor's actions in giving Patricia her abortion and the *de minimis* nature of State imposed restrictions on abortions, a brief review of the Virginia abortion statutes, Va. Code

§ 18.2-71 *et seq.*, is helpful at this juncture. These statutes were recodified in 1975 to comply with *Roe* v. *Wade*, 410 U.S. 113 (1973). In 1979 at the time this crime occurred and now, Virginia law permits a physician licensed by the Commonwealth in the practice of medicine and surgery to perform an abortion on any woman during the first trimester of pregnancy. (Va. Code § 18.2-72) No restrictions or conditions are imposed on the physician except that he inform the woman of the nature of the proposed procedure to be utilized and the risks, if any, and obtain her informed written consent. (Va. Code § 18.2-76) Similarly, such a physician may perform an abortion on any woman during the second trimester of pregnancy subject to the sole additional requirement that "such procedure is performed in a hospital licensed by the State Department of Health. . . ." (Va. Code § 18.2-73) Such a physician may perform an abortion in such a hospital on a woman in her third trimester of pregnancy provided two other physicians certify that in their medical opinion the continuation of the pregnancy "is likely to result in the death of the woman or substantially and irremediably impair [her] mental or physical health." (Va. Code § 18.2-74) In third trimester abortions, measures for life support for the fetus "must be available and utilized if there is any clearly visible evidence of viability." (Va. Code § 18.2-74) By statute, parental consent is not required for abortions performed on minors unless the woman is incompetent, and then other alternatives are available. (Va. Code § 18.2-76 and § 54-325.2 (D) (2)) A final section exempts from penal provisions and the provisions relating to first, second, and third trimester abortions, the action of any physician in performing an abortion "on any woman" if, in his opinion, it is necessary in order to save her life. (Va. Code § 18.2-74.1)

Except as described above, persons performing an abortion in Virginia are guilty of a felony under Virginia law. (Va. Code § 18.2-71) As interpreted by the Supreme Court of Virginia, "abortion," as used in the Virginia statutes, is not limited to the mere expulsion of the fetus, but includes the use of any means with intent to destroy an unborn child resulting in the destruction of such child or in producing an abortion. Thus, both the "means and the ensuing process" are embraced by the statute. *Simopoulos* v. *Commonwealth*, 221 Va. 1059, 1067, 277 S.E.2d 194, 199 (1981).

B.

Patricia's Abortion

In order to obtain her abortion, Patricia contacted several clinics to find out about prices, (J.A. 281-282), and settled upon Dr. Simopoulos' office in Falls Church, Virginia, known as the American Women's Clinic. Patricia made an appointment to see the Doctor on November 8, 1979. At that time, Simopoulos' office and clinic was not certified or licensed as an outpatient hospital; nor had he sought such certification. (J.A. 209)

Patricia testified that when she first went to the clinic she was scared but not depressed. She did not want her parents to learn of the situation. (J.A. 283) When she met Simopoulos, Patricia told him that she was "about 22 weeks pregnant."[1] (J.A. 268) He performed a pelvic examination on her and noted in his records that she was five

[1] The autopsy report estimated the gestational age of the fetus at "5½ months." It weighed 495 gms. (J.A. 315)

Simopoulos' repeated implication that Patricia was 16 weeks pregnant, (Brief for Appellant at 5, 27), underscores the paucity of his case and belies the facts. Of course, the risks and complications attendant to abortions increase significantly as the pregnancy progresses into the second trimester. See Argument, *infra*, at 20-24.

months pregnant. (J.A. 249) Patricia testified that Simopoulos

> asked me if my parents knew about it and I told him no. He asked me what I was going to do, where I was going to go and I told him a motel. He said it was okay. It was possible to do it at home.

(J.A. 269, see also J.A. 283-284, 292) Patricia was in Simopoulos' office "around 15 to 30 minutes" on that day. (J.A. 269)

Simopoulos testified that they discussed the saline procedure which he would use and he "was under the distinct impression that she understood and she understood *all the risks and complications* that do arise as a result of the procedure." (J.A. 388) [Emphasis added.] After that examination, Simopoulos noted in his records, "scheduled for saline injection." (J.A. 249, 419) He further noted in his records that Patricia's condition was "normal." (J.A. 248-250) He did not make any notation indicating that he found Patricia to be depressed or in need of an abortion in order to save her life. (J.A. 417)

Two days later on November 10, Patricia returned to Simopoulos' office to receive the scheduled injection. At that time, Simopoulos performed, in his medical office, a saline amniocentesis. (J.A. 270-271) This procedure consists of injecting a saline solution through the expectant mother's abdomen into her amniotic sac. (J.A. 18-19) The entire procedure, including scrubbing, took no longer than thirty minutes. (J.A. 414) If the procedure worked as expected, Simopoulos anticipated that the fetus would die and be expelled within approximately two days of the saline injection. (J.A. 409, 430-431) After completion of the procedure, Patricia dressed and left the office about five minutes later. (J.A. 272)

For the two visits, which consumed at most sixty minutes of Simopoulos' time in his office, Patricia paid him $495. She had received the money as a loan on her VISA credit card.

Prior to Patricia's leaving Simopoulos' office on November 10, Simopoulos' receptionist gave her a list of postoperative instructions. The instructions stated that the patient should report to the hospital when contractions lasting thirty seconds begin occurring ten minutes apart, and, in any event, the patient should go to the hospital when the amniotic fluid breaks. The instructions also included Simopoulos' telephone number. (Defendant's Exhibit 3) (J.A. 199, 221)

After leaving Simopoulos' office, Patricia went to the motel with her boyfriend as she had previously advised the doctor. (J.A. 269, 273-274) On the way, she read the postoperative instructions. (J.A. 284) She stated at trial that she had not previously had time to read them. (J.A. 285) Patricia "thought it was pretty strange that [the instructions stated report to the hospital] when he [Simopoulos] told me something different." (J.A. 290)

Patricia's boyfriend stayed with her at the motel for some time and then left. While she was there, she ate some peanut butter and jelly sandwiches. (J.A. 286) Later, approximately forty-eight hours after having been injected and ten hours after her labor began, Patricia, alone, delivered her fetus in the bathroom of the motel room. (J.A. 276) Soon thereafter, she checked out of the motel and left the fetus in a trash basket in the bathroom. (J.A. 212)

Patricia left the fetus in the motel because she was scared. Although she still had Simopoulos' telephone number, she did not call him because, as she stated at trial, "I was scared and I was hurting and I just wanted to go home and I was in shock because no one ever told me that

was going to happen." (J.A. 295) Simopoulos had told Patricia that "the fetus was destroyed," (J.A. 296), and she had anticipated that "it was going to be was [sic] just blood." (J.A. 297) She further stated that Simopoulos had not advised her at all as to what to expect at the time of delivery. (J.A. 277)

Simopoulos testified in his own behalf. He admitted that he did what Patricia requested him to do. (J.A. 438) Indeed, he "left it up to her." (J.A. 421) He admitted that he injected salt in Patricia "in an effort to have [her] pregnancy terminated." (J.A. 406) He admitted that he intended that the fetus die as a result of his procedure. (J.A. 412) Simopoulos further admitted that, if the procedure worked, "the effect of my procedure...would be to terminate an unwanted pregnancy at five months gestation." (J.A. 409) Simopoulos admitted performing the procedure in his office which, by stipulation, was admitted not to be a licensed or certified outpatient hospital.

Simopoulos was indicted for unlawfully performing an abortion during the second trimester of pregnancy outside of a hospital licensed by the State. He was tried and convicted by a Judge of the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia reviewed his case and, in a unanimous decision, affirmed his conviction. *Simopoulos* v. *Commonwealth,* 221 Va. 1059, 277 S.E.2d 194 (1981). This appeal followed.

SUMMARY OF ARGUMENT

It was unnecessary in this case for the Indictment, affirmatively and in detail, to negate the medical necessity exception to Virginia's abortion statutes. The indictment adequately informed Simopoulos of the charge against him

and of its essential elements. Nothing more is constitutionally required.

The authoritative construction of the Virginia statutes by the Supreme Court of Virginia makes it clear that, in this case, the prosecution was not obligated to prove lack of medical necessity because Simopoulos never invoked the claim of medical necessity as a defense. The requirement that the defendant merely *invoke* medical necessity as a defense before the prosecution becomes obligated to prove the lack of same beyond a reasonable doubt does not impermissibly shift to the defendant the burden of proof. Simopoulos' reliance on *United States* v. *Vuitch*, 402 U.S. 62 (1971), is misplaced because the Virginia statute does not presume the doctor guilty and under no circumstances is he required to introduce evidence to prove his innocence. He merely must *invoke* an exception to the criminal statute as a defense before the prosecution becomes obligated to affirmatively negate the exception.

In this case, it was necessary for the prosecution to prove (1) that Patricia was in the second trimester of her pregnancy, (2) that Simopoulos performed a saline amniocentesis on her with the intent that it cause the death or expulsion of her fetus, (3) that the procedure was administered outside of a hospital licensed by the Commonwealth and (4) that the administration of the procedure resulted in the death or expulsion of the fetus. The evidence on each element is overwhelming and easily permitted the trial court, as a rational trier of fact, to find Simopoulos guilty beyond a reasonable doubt.

Substantial scientific data supports the conclusion that second trimester saline abortions are not without significant complications including hypernatremia, immediate labor, bleeding and infection, disseminated intravascular coagu-

lation, retained placenta, sepsis, cervical and vaginal laceration or fistula, emotional difficulties, live births and maternal death. This data verifies the correctness of this Court's pronouncement in *Roe* v. *Wade,* 410 U.S. at 163, that States, in protecting maternal health, may require second trimester abortions to take place in licensed hospitals.

The Virginia hospitalization requirement does not limit access to abortions as Simopoulos would have the Court believe. Virginia does not require that the procedure be performed exclusively in acute care, general hospitals. Virginia Code § 32.1-123 defines "hospital" broadly. Under the Rules And Regulations For Licensure Of Outpatient Hospitals (1977), ADDENDUM 1, outpatient clinics may qualify for licensure as hospitals in which second trimester abortions may be lawully performed.

The fact that some private hospitals may require parental consent for abortion is not the kind of restriction on abortion that entitles Simopoulos to relief. Such a requirement is not State mandated or even State encouraged. By statute, State hospitals may not require parental consent.

There is no restriction in the Virginia statutes or Rules as to when or how a second trimester abortion is to be performed. Thus, the statutes accommodate medical advances and leave the medically related decisions to the doctor and his patient.

Simopoulos does not have standing to challenge the hospitalization requirement on the grounds of overbreadth. The abortion in this case was one performed on a woman in the twenty-second week of pregnancy and the procedure used may result in substantial complications. Whether the statute is overboard for fifteen week abortions using other procedures is not at issue. Simopoulos' factual situation precludes that argument.

Nevertheless, assuming standing *arguendo*, the fact that some second trimester abortions may be successfully performed in a doctor's unlicensed office is not determinative. The State is not required to fine-tune its statutes to facilitate or encourage abortions. The broad range of facilities which might meet the Virginia definition of hospital makes the hospitalization requirement a narrowly drawn requirement designed to facilitate maternal health.

Therefore, the Commonwealth's statutes and Simopoulos' conviction should both be sustained.

ARGUMENT

I

The Virginia Statute Does Not Violate Due Process By Failing To Require That The Prosecution Affirmatively Negate The Medical Necessity Exception When The Defendant Does Not Invoke That Exception As A Defense.

Simopoulos contends that the indictment against him must affirmatively allege that the abortion was unnecessary to save Patricia's life and that, further, the Commonwealth was obligated to prove that fact. He contends that the indictment failed to so allege and this failure, together with the Commonwealth's failure to disprove medical necessity, impermissibly shifted the burden of proof to him in violation of this Court's decision in *United States* v. *Vuitch*, 402 U.S. 62, 71 (1971).[2] These contentions are without merit.

[2] In pertinent part, the indictment charged that Simopoulos "did unlawfully and feloniously, during the second trimester of pregnancy and outside of a hospital licensed by the State . . . use means upon [Patricia] . . . with the intent to produce abortion and thereby destroy her unborn child."

A.

THE INDICTMENT MET CONSTITUTIONAL REQUIREMENTS AND DID NOT IMPERMISSIBLY SHIFT THE BURDEN OF PROOF.

The Supreme Court of Virginia has authoritatively construed the Virginia abortion statutes. Under Virginia law, when a statute makes an action unlawful and a substantive clause subsequent to the enacting clause of the statute provides for an exception, then it is a matter of defense for the defendant to invoke the exception. The indictment need not deny the exception. If the defendant merely invokes the exception, then the Commonwealth has the burden of negating the exception beyond a reasonable doubt. *Simopoulos* v. *Commonwealth*, 221 Va. at 1069, 277 S.E.2d at 200.[3]

In this case, Simopoulos *never* invoked as a defense *the claim* that he was acting only out of necessity to preserve Patricia's life. Nor did he assert that such was the basis for his act. Thus, there was no obligation upon the Commonwealth to negate the exception with proof beyond a reasonable doubt.[4] It is true that, relying upon *United States* v. *Vuitch*, defense counsel argued that the indictment must "negate all exceptions," (J.A. 195-197, 456-457), but he never claimed that Simopoulos was acting on the premise

[3] This construction is consistent with the case law of other states: *Lingle* v. *State*, 51 Ala. App. 210, 283 So.2d 660 (1973); *State* v. *Orsini*, 155 Conn. 367, 232 A.2d 907 (1967); *State* v. *Bridges*, 412 S.W.2d 455, 457 (Mo. 1967).

[4] Even assuming *arguendo* that the indictment was required to negate the exception, it did so by alleging that Simopoulos "did *unlawfully* and *feloniously* . . . use means . . . ." (Emphasis added). The use of the term "unlawfully and feloniously" negates any lawful exception which might, if properly invoked, justify the defendant's action. See *Commonwealth* v. *Brunelle*, 341 Mass. 675, 678, 171 N.E.2d 850, 852 (1961).

that the abortion was necessary in order to save Patricia's life.[5]

The Supreme Court of Virginia's construction of the Virginia statute does not conflict with *Vuitch*. That case concerned "presumed guilt," 402 U.S. at 70, and the suggestion that under the District of Columbia statute the doctor "was required 'to come forward with evidence which with or without other evidence is sufficient to create a reasonable doubt of guilt'." 402 U.S. at 69. It was in the face of that argument that the *Vuitch* Court construed the enacting clause of the statute which incorporated the exemption to put the burden upon the prosecution to allege and prove that the defendant was not within the exception. 402 U.S. at 70.

The Virginia statute, as authoritatively construed by the Virginia Court, does not presume guilt; nor does it place any burden on the doctor to produce even a scintilla of evidence to prove his innocence. At most, the doctor must only "invoke" medical necessity as a defense and then the Commonwealth must carry the "burden of negating maternal health necessity beyond a reasonable doubt." *Simopoulos* v. *Commonwealth*, 221 Va. at 1069, 277 S.E.2d at 200.

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[5] Indeed, the following colloquy between the trial court and defense counsel when the latter was arguing the obligation of the prosecution is instructive:

> THE COURT: Well, if Mr. Horan [the prosecutor] stands up and shows this man has committed an abortion, period, and rests his case, then what happens from there?
>
> Mr. HINES [defense counsel]: I think he also has to show that if it was performed in second trimester that it was not performed in a place allowed by law and that the Defendant has the requisite general intent to violate those statutes. Not the specific intent. We are not talking about specific intent but the general intent to violate the statute.

(J.A. 137) At no time in that exchange did defense counsel argue that further proof was required to negate the never asserted claim of medical necessity.

In this case, the indictment fairly informed Simopoulos of the charge against him and of its nature. *Hamlin* v. *United States,* 418 U.S. 87, 117 (1974). It conformed to the requirements of State law which are binding upon this Court. *Coleman* v. *Alabama,* 399 U.S. 1, 9 (1970). It does not unconstitutionally implicate burdens of proof. *See Engle* v. *Isaac,* 50 U.S.L.W. 4376, (U.S. Apr. 5, 1982); *Patterson* v. *New York,* 432 U.S. 197, 201-202 (1977). Accordingly, the Commonwealth respectfully submits that Simopoulos' argument in this regard is unavailing and the indictment must be upheld.

B.

ALTHOUGH THE COMMONWEALTH WAS NOT REQUIRED TO INTRODUCE EVIDENCE OF LACK OF MEDICAL NECESSITY, SUFFICIENT EVIDENCE WAS PRODUCED TO PROVE SUCH BEYOND A REASONABLE DOUBT.

The only reason which Patricia gave for seeing Simopoulos was "[t]o have an abortion." (J.A. 264) Indeed, according to the doctor's notes, the condition of his twenty-two week pregnant patient was "normal." No other notation was made. Simopoulos admitted that at the end of Patricia's first visit "[s]he was calm, composed, relieved, but then to exercise the choice, the option of abortion, was entirely up to her and I had no business in influencing her one way or the other." (J.A. 438) Patricia went to Simopoulos for an abortion and he candidly admitted that he did "what the patient requested [him] to do to help her."[6] (J.A. 438) He simply "left it up to her."[7] (J.A. 421)

[6] Under Virginia law, when a defendant in a criminal case presents evidence, he waives his right to rely on his motion to strike. In such a situation, the court may fairly consider evidence which the defendant has presented when reviewing his claim of lack of sufficiency of the evidence. *Tolley* v. *Commonwealth,* 216 Va. 341, 347, 218 S.E.2d 550, 554 (1975).

[7] The relationship which Simopoulos described is hardly the intimate relationship of medical counsellor—patient in need of medical

Simopoulos' description of Patricia as far more depressed than the usual patient and his intimation of concern over possible suicide, (Brief For Appellant 18), is flatly contradicted by Patricia's testimony. She freely admitted being "scared, but nothing else." (J.A. 282) She was not depressed. (J.A. 282) Simopoulos' description is further belied by his failure to note in his records anything other than the fact that Patricia was "normal" and by his admission that "I had no business in influencing her one way or the other."

While such a finding is unnecessary due to Simopoulos' failure to invoke the medical necessity exception,[8] the foregoing facts are certainly adequate to permit a rational trier of fact, such as the trial court here, to find beyond a reasonable doubt that the abortion was not medically necessary in order to save Patricia's life. See *Jackson* v. *Virginia*, 443 U.S. 307, 319 (1979).

II

The Commonwealth Produced Sufficient Evidence To Enable A Rational Trier Of Fact To Find Guilt Beyond A Reasonable Doubt.

In arguing that the Commonwealth failed to prove that the saline amniocentesis caused the death of the fetus, Simopoulos claims that the prosecution was obligated to pro-

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advice contemplated by this Court in *Doe* v. *Bolton*, 410 U.S. 179, 196-197 (1973). See American Medical Association 1970 resolution discussed in *Roe* v. *Wade*, 410 U.S. at 143. That resolution emphasized "the best interests of the patient" and "sound clinical judgment" in contrast to "mere acquiescence to the patient's demand."

[8] Simopoulos' contention that the Commonwealth has conceded that it must show lack of medical necessity, (Brief of Appellant at 19), is another erroneous and unsupportable assertion. In the Commonwealth's Motion to Dismiss which Simopoulos cites, the Commonwealth conceded only that it must show lack of medical necessity when

duce (1) "some evidence" of the type of saline solution instilled, (2) the amount needed to cause an abortion, (3) that the fetus had vital signs before the instillation, (4) evidence that an examination of the fetus showed that the injection caused its demise, and (5) an absence of reasonably possible intervening causes. (Brief For Appellant at 25.) Such assertions are unsupportable and can be made only to divert the Court's attention from the wealth of evidence adduced at trial which clearly proved guilt beyond a reasonable doubt.

The Record reveals that on Thursday Patricia went to Simopoulos specifically for an abortion and advised him that she was twenty-two weeks pregnant. (J.A. 268) Simopoulos performed "a thorough physical examination on her," (J.A. 383), and noted that her condition was "normal." It is totally illogical even to entertain the notion that the fetus was dead at that time. Had it been, Simopoulos would have observed that condition and so stated rather than simply noting that the condition was "normal."[9] Moreover, Simopoulos' testimony that he informed Patricia that she had the option "to carry the pregnancy to term," (J.A. 384), makes it too clear to be doubted that the fetus was alive.

Two days later, on Saturday, Simopoulos injected Patricia with a saline solution. (J.A. 271) That same day she went to a motel and stayed until noon, Monday. (J.A. 273-275) During that time, Patricia did not take any medication except the pain pills which had been prescribed by Simopou-

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the defense is "once asserted." As demonstrated above, Simopoulos failed to make such an assertion and, therefore, in this case the Commonwealth is not under an obligation to show lack of medical necessity.

[9] Such a determination could certainly have been made on a twenty-two week pregnant patient. Pritchard and McDonald, *Williams Obstetrics,* 204-215, 246-250. (15th ed. 1976).

los. (J.A. 286) Patricia went into labor late Sunday night or early Monday morning. (J.A. 275) The medical evidence revealed that the fetus was born dead and was of the approximate gestational age of five and one-half months. (J.A. 232-236)

Simopoulos' records show that Patricia was injected with a saline solution and that the procedure was performed without complication. (J.A. 250) Simopoulos admitted that the injection of saline was for the purpose of an abortion and that the procedure went well. (J.A. 406) He testified that if the procedure succeeded, the fetus would be destroyed, (J.A. 408-409), and that was his intent.[10] After the procedure was performed, Simopoulos told Patricia that the fetus was destroyed. (J.A. 296) Simopoulos admitted that his office where the procedure was administered was not a State licensed outpatient hospital. (J.A. 209)

In *Jackson* v. *Virginia,* this Court noted that in reviewing questions on sufficiency of evidence in criminal matters, the evidence must be viewed in the light most favorable to the prosecution. 443 U.S. at 319. There, this Court ruled that the prosecutor was not under an affirmative duty to rule out every hypothesis except that of guilt. 443 U.S. at 326. To the contrary, it is enough that the facts be sufficient to permit *any* rational trier of fact to have found the essential elements of the crime. 443 U.S. at 319.

In the case at bar, the facts clearly permit a rational trier of fact to find beyond a reasonable doubt that Simopoulos administered to a twenty-two week pregnant woman a procedure outside of a hospital licensed by the State with the

[10] In *Colautti* v. *Franklin,* 439 U.S. 379, 398 (1979), this Court recognized that saline amnioinfusion nearly always is fatal to the fetus. Dr. Soyster, a witness for Simopoulos in this case, testified that the likelihood of a saline amniocentesis not resulting in fetal death is only 5 to 15 per cent. (J.A. 332)

intent that the procedure result in the death or expulsion of the fetus and that such death or expulsion occurred as a result of Simopoulos' instillation procedure. The trial judge found the evidence to be "incredibly strong," (J.A. 307), and the Commonwealth respectfully submits that it is more than adequate to prove Simopoulos guilty beyond a reasonable doubt. Accordingly, this second basis for Simopoulos' appeal is without merit and should be rejected.

III

The Virginia Hospitalization Requirement For Second Trimester Abortions Does Not Unconstitutionally Restrict A Woman's Right Of Privacy.

In *Roe* v. *Wade*, the Court through "extensive historical fact and a wealth of legal scholarship"[11] exhaustively analyzed abortions, the woman's right to privacy, and the State's "important and legitimate interest in the health of the mother." 410 U.S. at 163. The Court rejected the notion that a woman has an absolute right to an abortion without any interference from the State. This Court held in *Roe* that the State's interest in maternal health becomes compelling at approximately the end of the first trimester of pregnancy. Accordingly, this Court held that, from and after that time, the State may regulate the abortion procedure. Undoubtedly, in order to insure clarity and an understanding of the nature of constitutional State regulation, this Court, in great detail, observed,

> Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in

[11] See Mr. Justice Rehnquist's dissenting opinion, 410 U.S. at 171.

> which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.

Roe, 410 U.S. at 163.

Without even acknowledging this portion of the *Roe* opinion, Simopoulos argues that the Commonwealth's hospitalization requirement is now unconstitutional. Thus, he contends that what this Court specifically ruled to be constitutional in 1973 had, by 1979, mysteriously become unconstitutional. His argument is contrary to law and logic and should not prevail.

A.

The Standard Of Review

In considering the standard of review, several cases are particularly helpful and instructive. Of course, *Roe* v. *Wade* did not declare an unqualified constitutional right to an abortion; rather the *Roe* "right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy." *Maher* v. *Roe*, 432 U.S. 464, 473-474 (1977). In *Maher*, the Court applied the rational basis test to a State decision not to fund abortions, a decision which obviously had a limiting affect on access to abortion. Moreover, in *H. L.* v. *Matheson*, 450 U.S. 398 (1981), the Court applied the rational basis test to a State parental notification statute which applied even to first trimester abortions and which the Court recognized "may inhibit some minors from seeking abortions. . . ." 450 U.S. at 413.

Virginia's hospitalization statute promotes maternal health. While it may have some impact on abortions, that

impact is not as great as the impact of the statute upheld in *Matheson* and certainly falls short of the impact of the statute upheld in *Maher*.

This Court has affirmed the principle that a state may "from and after the end of the first trimester, adopt standards for licensing all facilities where abortions may be performed so long as those standards are legitimately related to the objective the State seeks to accomplish." *Doe* v. *Bolton*, 410 U.S. 179, 194-195 (1973). The Virginia hospitalization requirement is designed to insure safety for the woman and does not unduly burden the woman's right to decide to terminate her pregnancy utilizing procedures "performed by medically competent personnel under conditions insuring maximum safety for the woman. *Connecticut* v. *Menillo*, 423 U.S. 9, 11 (1975). *See also, Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52, 79-81 (1976).

Under concepts articulated in *Matheson, Menillo* and *Danforth*, the Court may conclude that Virginia's hospitalization requirement does not infringe upon the woman's constitutional right to privacy.

Accordingly, the Commonwealth submits that the rational basis test is the appropriate standard for review of the hospitalization requirement. Nevertheless, should this Court require that the Commonwealth justify her statute as a compelling state interest, both the case law and the facts of this case mandate a conclusion that the Commonwealth has met the burden. *Roe* v. *Wade*, 410 U.S. at 163.

B.

THE COMMONWEALTH'S SECOND TRIMESTER HOSPITALIZATION REQUIREMENT IS A RATIONAL AND LEGITIMATE MEANS OF PROTECTING THE HEALTH OF A WOMAN WHO SEEKS TO TERMINATE A TWENTY-TWO WEEK PREGNANCY.

Before examining the medical basis for the hospitalization requirement, it is essential to understand, first, the nature of that requirement. Section 18.2-73 of the Code of Virginia requires only that second trimester abortions be "performed in a hospital licensed by the State Department of Health. . . ." Section 32.1-123 of the Code of Virginia defines "hospital" in pertinent part as any facility in which the primary function is the provision of medical and nursing services, surgical and nonsurgical including "outpatient . . . hospitals." To facilitate the licensing procedure, the Board of Health promulgated regulations "in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals. . . ." (Va. Code § 32.1-127 (A)) These standards and the licensing procedure permit the Health Department to license an outpatient, surgical clinic as a "hospital." Thus, under Virginia law, a second trimester abortion may be performed in an outpatient surgical clinic provided that clinic has been inspected and licensed as a hospital by the State. The State Health Department regulations do not require the involvement of an external accreditation body such as the Joint Commission on Accreditation of Hospitals as was the case in *Doe* v. *Bolton*, 410 U.S. at 192-195. Of course, in this case, Simopoulos never sought State licensure for his clinic prior to performing the abortion on Patricia. (J.A. 373)

Simopoulos concedes the legitimacy of Virginia's interest

in maternal health in the context of abortion.[12] Twenty-eight thousand four hundred ninety-two legal abortions were performed on Virginians in Virginia in 1978.[13] Of this number, only 1,853 abortions, or 6.5% of the total, were performed after the 13th week of gestation.[14] Thus, less than 10% of the abortions were required to be performed in a hospital. The majority of second trimester abortions done in Virginia after the 20th week of gestation are performed by means of intrauterine instillation of saline.[15]

Second trimester abortions are not without complications.[16] Between 1972 and 1978, 79 women undergoing second trimester abortions in this country died as a result of the abortion procedure.[17] The risk of death for abortions done by instillation procedures was second only to second trimester abortions performed by means of hysterectomy or hysterotomy.[18] Estimates of the overall mortality rate asso-

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[12] Brief for Appellant at 38.

[13] 1978 Statistical Annual Report published by the Virginia Department of Health, 53. ADDENDUM 23.

[14] *Id.* at 54. ADDENDUM 25.

[15] *Id.* at 54. The Court should note that saline instillation is the predominant means of inducing abortion after the sixteenth week of gestation in at least 28 states. *Grimes, et al., The Brief for Hypertonic Saline,* 15 Contemporary Ob/Gyn. 29, 30 (1980). APPELLANTS ADDENDUM 29. *See also* Kawada, *Techniques of Second Trimester Abortion,* 20 Clinical Obstetrics and Gynecology 833, 837 (1977). ADDENDUM 64.

[16] Medical literature indicates that the earlier the abortion is performed the safer it is likely to be. Technical Bulletin of the American College of Obstetricians and Gynecologists, No. 56 (Dec. 1979) ADDENDUM 79 concludes that, "Regardless of advances in abortion technology, mid-trimester terminations will likely remain more hazardous, expensive, and emotionally disturbing for women than earlier abortions." *Id.* at 5. *See also* Justice Marshall's extensive review of literature indicating the medical preference for early abortions in *H. L.* v. *Matheson,* 450 U.S. 398, 439 n. 25 (1981) (Marshall, J. dissenting).

[17] Centers for Disease Control: Abortion Surveillance 1978, (Nov. 1980) 48. (Hereinafter Abortion Surveillance) ADDENDUM 45.

[18] *Id.* at 9.

ciated with saline amnioinfusion abortion range from 18 to 30 per 100,000 women.[19]

While the mortality rate is significant, the saline amniocentesis procedure may result in other serious complications, short of death, which demand the Court's attention. The possibility of these complications alone fully justifies the Commonwealth's hospitalization requirement. Among the complications is hypernatremia which may occur during or shortly after the injection of saline.[20] Caused by inadvertent injection of saline into the blood, tissue or peritoneal cavity, the affected patient will soon report acute pain, headache, and burning sensations. Later symptoms range from headache and lethargy to seizures, all of which result from excessive dehydration of the brain.[21]

Immediate labor is another complication associated with the instillation of saline. These women are at risk of bleeding from a blood clotting disorder (disseminated intravascular coagulation) and must be observed carefully.[22]

The medical literature verifies that bleeding and infection remain primary complications of labor and delivery following saline instillation and many articles discuss various aspects of these complications. Disseminated intravascular coagulation with clinical hemorrhage occurs at a rate of 1 per 1,200 women and may occur prior to delivery.[23] DIC, as this condition is frequently abbreviated, is a defect in the clotting mechanism of the blood which causes severe hemorrhage. Hemorrhage not related to DIC may occur

[19] Technical Bulletin of the American College of Obstetricians and Gynecologists. No. 37 (Feb. 1976). ADDENDUM 80.

Cates, *The Risk of Dying from Legal Abortion in the United States, 1972-1975*, 15 Int.J. Gynaecol. Obstet. 172, 175 (1977). ADDENDUM 87.

[20] Technical Bulletin, *supra*, No. 37. ADDENDUM 81.

[21] Kawada, *supra*, at 839. ADDENDUM 66.

[22] Technical Bulletin, *supra*, No. 37. ADDENDUM 81.

[23] *Id.*

during the process of labor and delivery and requires blood transfusions in at least 1-2% of women undergoing saline amnioinfusion.[24] The placenta or a portion of it is retained in 10-20% of women undergoing saline amnioinfusion.[25] If these conditions occur, prompt medical intervention is essential to prevent hemorrhage and infection.

Moreover, infections such as endometritis and urinary tract infections are frequently associated with saline abortions.[26] Sepsis, particularly when associated with disseminated intravascular coagulation, is a principal cause of death in patients undergoing saline amnioinfusion.[27] Cervical and vaginal laceration or fistulas may occur and are frequently found in patients who have long labors.[28] Perhaps the most difficult problem emotionally is that live births and survivals after saline abortion have been reported in pregnancies of more than 20 weeks.[29]

The record below is replete with reference to the substantial dangers of second trimester abortion. Dr. Harold Schulman, a defense witness, conceded on cross-examination by the Commonwealth's Attorney that a waiting period is necessary after saline is injected before the patient leaves the hospital or clinic "to see if there are any unusual reactions to the instillation of the solution."[30] (J.A. 37) Schulman testified that "[if a] disproportionate amount of the salt

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[24] *Id.*

[25] *Id. See also* Kawada, *supra,* 840.

[26] Technical Bulletin, *supra,* No. 56. ADDENDUM 78.

[27] Technical Bulletin, *supra,* No. 37. ADDENDUM 82.

[28] *Id.*

[29] *Id. See also* Stroh, *et al., Reported Live Births Following Induced Abortion: Two and One-half Years' Experience in Upstate New York,* 126 Am.J. Obstet. & Gynecol. 83 (1976). ADDENDUM 118.

[30] Contrast this observation with the facts of this case in which Patricia was permitted to leave the office five minutes after the injection. (Footnote continued on p. 23.)

solution somehow gets into her bloodstream she will give certain symptoms of thrist or headache, nausea, vomiting and on rare occasions the uterus will abruptly begin to swell." (hypernatremia) (J.A. 38) Schulman also testified that saline can interfere with the clotting mechanism in the blood and result in extensive hemorrhaging. (J.A. 38-39) Schulman was even familiar with some cases of maternal death due to "total evacuation of blood." (J.A. 39)

This substantial scientific data clearly justifies the Commonwealth's concern for women undergoing saline abortion.[31] Indeed, the mortality rate as well as serious complications mandate this concern. Clearly, a woman is better protected if the mid-trimester abortion is done in a facility which is equipped to perform the surgical procedures involved and which is equipped to deal with complications which may arise.[32] The hospitalization requirement contained in § 18.2-73 is nothing more than statutory recog-

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The State Board of Health Regulations for certification of outpatient hospitals require that patients undergoing surgical procedures in outpatient hospitals be observed by trained personnel for a minimum of sixty minutes to guard against post-operative complications. Rules and Regulations For the Licensure of Out-patient Hospitals in Virginia, § 43.9.2 (1977). ADDENDUM 20.

[31] As this Court recognized in *Roe* v. *Wade*, 410 U.S. at 150, "[t]he prevalence of high mortality rates at illegal 'abortion mills' strengthens, rather than weakens, the State's interest in regulating conditions under which abortions are performed." *See, Bellotti* v. *Baird*, 443 U.S. 622, 640-641 (1979); and *H. L.* v. *Matheson*, 450 U.S. 398, 420 n.8 (1981) (Powell, J., concurring.)

[32] Schiffer, *et al., Mortality Associated with Hypertonic Saline Abortion*, 42 Obstetrics and Gynecology 759 (1973). ADDENDUM 93.

Documents submitted on behalf of Simopoulos do not convincingly support Simopoulos' proposition that saline abortions are so safe that the performance of the procedure in a non-hospital facility is medically acceptable. (Brief for Appellant at 43.) In one study cited by Appellant, 80% of the patients aborted without requiring "much" medical support. APPELLANT'S ADDENDUM, at 51-56. If the remaining 20% of the women who aborted required medical inter-

nition of the medical fact that second trimester abortions may require certain technological support not necessary in the relatively safer first trimester abortions. The statute does not require that the patient be hospitalized as an inpatient. It also does not dictate the abortion procedure to be used nor the time frame in which the particular procedure is to be used.

Simopoulos' failure to avail himself of the hospital licensure provisions surely does not make the Commonwealth's hospitalization requirement unconstitutional. As this Court specifically recognized in *Roe* v. *Wade*, mid-trimester hospitalization is an acceptable "regulation reasonably related to the perservation and protection of maternal health." 410 U.S. at 163. The facts of this case do not require or even permit the Court to reach the opposite conclusion. This is particularly true in light of the fact that Virginia permits the procedure to be administered in a licensed outpatient facility.

C.

The Hospitalization Requirement Does Not Unduly Restrict Access Of A Pregnant Female To A Mid-Trimester Abortion.

Simopoulos contends that the hospitalization requirement unduly restricts access to second trimester abortions by effectively leaving the pregnant woman at the mercy of

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vention because they were "plagued" with problems, that can only be considered a significant complication rate. A 20% complication rate supports rather than contradicts hospitalization requirements. In another study cited by Simopoulos, the authors conceded that they did not know what happened to 16% of the patients who received saline instillation (APPELLANT'S ADDENDUM, 18-23). One notes further that authors Schulman and Neubardt cited by Simopoulos generally support saline instillation as an ambulatory procedure. Nevertheless, the patients described by these authors were treated in a controlled medical environment.

local hospital governing boards which may prohibit the procedure altogether or require parental consent in the case of minors.

The answers to these contentions are both factual and legal in nature. With respect to the facts, the record does not support Simopoulos' assertion that only two of sixteen Northern Virginia hospitals provide second trimester abortions.[33] The two area physicians on whose testimony he relies acknowledged that they knew only the policies at the hospitals where they had privileges. (J.A. 101-102, 148) The other testimony, that of Emily Moore, a sociologist who conducted a purported telephone survey, was excluded by the trial Judge.[34] It is worthy to note that the affidavit of the State Health Commissioner filed in *Simopoulos* v. *Coleman,* C.A. 81-9476A (E.D. Va., Sept. 2, 1981), which involved the same parties and in which judgment was granted to the Commonwealth for reasons not pertinent to this case, states that of the thirty-six general, acute care hospitals performing second trimester abortions in the Commonwealth in 1978, at least four were in Northern Virginia. (See ADDENDUM 47-48, 50) Moreover, if one considers the possibility of numerous additional outpatient hospitals, it is clear that the hospitalization requirement

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[33] A review of the testimony on which Simopoulos relies discloses that the witnesses, in referring to hospitals, contemplated only general hospitals or acute care in-patient hospitals. (J.A. 98-105, 127-128, 148) Of course, as demonstrated above, many additional outpatient hospitals may exist in the area.

[34] An indication of the lack of credibility to which Dr. Moore's survey is entitled is revealed by her comment:

> The hospitals will frequently refer you when you are inquiring about hospital policies and they say, well, it really isn't up to us, it is up to the doctors. Some further investigations suggest that that is not entirely the case. That if you ask for a different office of the hospital, you can.

(J.A. 131)

does not impose an undue restriction on a woman's access to abortion.

There is also a ready legal answer to Simopoulos' contention that the Commonwealth has blocked access by acquiescing in private hospital policies which either preclude second trimester abortions from being performed or require parental consent in the cases of unmarried minors. In *Harris* v. *McRae*, 448 U.S. 297, 316 (1980), the Court held that while "government may not place obstacles in the path of a woman's exercise of her freedom of choice, *it need not remove those not of its own creation.*"[35] [Emphasis added.] In *Doe* v. *Bolton*, 410 U.S. 179, 197-198 (1973), this Court acknowledged the appropriateness of a State statute which permitted physicians or hospitals to refrain for moral or religious reasons from participating in the abortion procedure. And, of course, the Court has held that a State is not constitutionally mandated to fund abortons. *Maher* v. *Roe*, 432 U.S. 464, 474 (1977).

The policy decision of Fairfax Hospital, the private, acute care general hospital at which Simopoulos preferred to practice, to require parental consent of minors seeking midtrimester abortions in that institution was not an obstacle placed in Patricia's path by the Commonwealth of Virginia. Simopoulos' perceived restrictions on Patricia's access to an abortion were not a product of governmental restrictions on abortions, but rather of (1) Patricia's per-

[35] In *Flagg Bros., Inc.* v. *Brooks*, 436 U.S. 149, 164 (1978), this Court noted that

> [O]ur cases state 'that a State is responsible for the . . . act of a private party when the State, by its laws, has compelled the act.' *Adickes* 398 U.S. at 170. This Court, however, has never held that a State's mere acquiescence in a private action converts that action into that of the State.

Accord, Blum v. *Yaretsky*, 50 U.S.L.W. 4859 (U.S. June 25, 1982), *Rendell-Baker et al.* v. *Kohn*, 50 U.S.L.W. 4825 (U.S. June 25, 1982).

sonal relationship with her parents; or (2) Fairfax Hospital's relationship to its governing board, or (3) Simopoulos' own failure to obtain the appropriate certification as an outpatient hospital from the Virginia Department of Health.

D.

THE HOSPITALIZATION REQUIREMENT FOR MID-TRIMESTER ABORTION IS NOT UNCONSTITUTIONAL FOR REASONS OF OVERBREADTH.

Simopoulos contends that the hospitalization requirement is unconstitutionally overly broad because second trimester abortions may be safely performed outside of hospitals. He contends that the Commonwealth has failed to demonstrate the need for the requirement in light of other alternatives.

It may be true that certain newly developed procedures such as dilatation and evacuation may be performed relatively safely and have mortality risks less than the mortality risk from childbirth.[36] Simopoulos, however, does not have standing to rely upon those new developments in attacking

[36] Statistics for certain second trimester abortions such as dilatation and evacuation suggest that that particular procedure has a mortality rate (7.7 per 100,000 abortions) which is less than mortality from childbirth. (9.9 deaths per 100,000 births). Abortion Surveillance, 1978, *supra*, at 49; Pritchard and MacDonald, *Williams Obstetrics*, 4 (16th ed. 1980).

The mortality rate for saline instillation after 16 weeks gestation is approximately 18 deaths per 100,000 abortions. Abortion Surveillance, 1978, *supra*, at 49. ADDENDUM 49, 99-100.

Studies from the Centers for Disease Control in Atlanta have concluded that the dilatation and evacuation procedure can be used advantageously in the 13-15 week gestation interval without hospitalization. Cates, *et al., Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities*, 58 Obstetrics and Gynecology 401 (1981). Dr. Cates, who has consistently promoted reconsideration of mandatory hospitalization laws, nevertheless concedes that 16 weeks gestation is a medically appropriate time to require hospitalization for abortions. ADDENDUM 101.

the hospitalization requirement. He performed a saline amniocentesis, a procedure for which mortality and morbidity rates have been documented, *supra*. Simopoulos lacks, therefore, the " 'personal stake in the controversy needed to confer standing' to advance the overbreadth argument." *H. L.* v. *Matheson*, 450 U.S. 398, 406 (1981).

Assuming for purposes of argument that Simopoulos does have standing to advance the overbreadth argument, he still cannot prove that the hospitalization requirement is unduly burdensome or irrational. The medical advances which have made abortion safer and easier have also made fetal viability possible at an increasingly earlier gestational age.[37] Thus, although medical technology may well have delayed the state's interest in maternal health in the course of human pregnancy, it has also placed the state's interest in potential life at an earlier point in pregnancy.

The human pregnancy is a continuum in which the interest of the mother in her privacy and the interest of the State in her health or potential life are greater or lesser depending upon the stage of pregnancy. A regulatory scheme which leaves the timing and type of the abortion prior to the determination of viability to medical expertise does not violate any of the involved interests at any given point. The second trimester hospitalization requirement does, however, assure that safe clinical conditions will be available to protect whichever interest predominates at any

[37] Increasingly earlier fetal viability has been demonstrated with babies born alive who are less than 25 weeks gestational age and who weigh between 500 and 1,249 grams. Studies have documented a 20% survival rate for these infants. Philip, *et al., Neonatal Mortality Risk for the Eighties: The Importance of Birth Weight/Gestational Age Groups*, 68 Pediatrics 122-130, (1981). The fetus in the Simopoulos case weighed 495 grams and was approximately 22 gestational weeks. ADDENDUM 109, 112.

given point after the first trimester without constant litigation or revision of law.

The Virginia hospitalization requirement does not restrict all second trimester abortions to general, acute care hospitals as Simopoulos would have the Court believe. Section 18.2-73, as previously indicated, requires only that the mid-trimester abortion be performed in a hospital licensed by the Virginia State Department of Health or under the control of the State Board of Mental Health and Mental Retardation.

As a general proposition, physicians' offices are not regulated under present Virginia law.[28] A physician is not required to keep medical records or hire registered nurses. He is not compelled to keep up with current developments in medicine, nor is he required to develop operative protocols or emergency procedures.

By contrast, the Rules and Regulations for the Licensure of Out-Patient Hospitals, Parts I and II,[29] require that outpatient facilities develop written policies and procedures with respect to the operative procedures to be performed, the anesthesia to be available, the patient consent forms to be used, and infection control. The Rules require that only physicians perform surgical procedures and that at least one registered nurse be available at all times the facility is

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[28] §§ 54-273 through 54-325.15 of the Code of Virginia; Rules and Regulations of the Healing Arts Licensed and Regulated by the Board of Medicine (1981).

[29] The Rules and Regulations pertaining to outpatient facilities were revised in Nov. 1981, effective May 1, 1982. The Rules promulgated in 1977 and the revised rules are consistent with the standards for free standing surgical clinics suggested by the American College of Obstetricians and Gynecologists. See the brief *Amici Curiae* of the American College of Obstetricians and Gynecologists and other medical groups, n. 65 at 24, filed in *City of Akron* v. *Akron Center for Reproduction Health, Inc.*, Nos. 81-746 and 81-1172 to be argued this term.

in use. The Rules further require that preparations be made for emergency services. Monitoring equipment, suction and resuscitation equipment must also be available as well as means to control hemorrhage.

If a Virginia physician wanted to perform a broad spectrum of ob-gyn procedures including second trimester abortion outside of a general hospital, he could do so lawfully in his own clinic, provided his facility is licensed as an outpatient hospital by the Virginia State Department of Health. While the record reflects that at the time of trial Simopoulos had sought such certification for his clinic, (J.A. 373), at the time of the offense he had not sought such certification.

The State has a legitimate interest in seeing to it that

> abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise.

Roe, 410 U.S. at 150. The proposition that abortion in general has a relatively low mortality rate or may be safer than childbirth[40] should not preclude the State from intervening to protect maternal health in the second trimester or, if appropriate, potential life regardless of the gestational week. The *Roe* Court found that even though the State's interest in protecting the woman from an "inherently hazardous procedure" has effectively disappeared, important state interests in health and medical standards remain. *Roe*, 410 U.S. at 149.

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[40] LeBolt, *et al., Mortality from Abortion and Childbirth: Are the Populations Comparable?* 248 Journal of the American Medical Association 188 (1982). APPELLANT'S ADDENDUM 1.

The Virginia hospitalization requirement, in conjunction with the Rules and Regulations for the Licensure of Out-Patient Hospitals in Virginia, accommodates medical advances and leaves the type and timing of the abortion precisely where it belongs—between the physician and his patient. It is true that § 18.2-73 ultimately requires that certain technological support and safety mechanisms be available if a woman is undergoing a mid-trimester abortion. Such general licensing requirements have, however, long been recognized as lawful exercise of State power.[41] The State has broad power to enact and effect protection of the public health and safety. The fact that some mid-trimester abortions may be done successfully in a minimally equipped doctor's office or at home does not invalidate § 18.2-73.[42] The State is not required to fine tune its statutes to facilitate or encourage abortions. *H. L.* v. *Matheson,* 450 U.S. at 413; cf., *Ohralik* v. *Ohio State Bar Ass'n.,* 436 U.S. 447, 464 (1978).

Since *Roe,* this Court has affirmed decisions upholding hospitalization requirements. For example, injunctive relief from an Indiana statute requiring that second trimester abortions be performed in a hospital was denied by a three judge District Court in *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen,* 421 F.Supp. 734 (N.D. Ind. 1976). That judgment was affirmed by this Court in *Bowen* v. *Gary-Northwest Indiana Women's Services, Inc.,* 429 U.S. 1067 (1977).

In *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen,* 496 F.Supp. 894 (N.D. Ind. 1980), the plaintiffs

[41] *Williamson* v. *Lee Optical Co.,* 348 U.S. 483 (1955); *see North Dakota Pharmacy Bd.* v. *Snyder's Stores,* 414 U.S. 156 (1973).

[42] In *Planned Parenthood Ass'n.* v. *Ashcroft,* Nos. 81-1255 and 81-1623, to be argued this term, the plaintiffs actually conceded that and evacuation should be performed only in a hospital. See in that second trimester abortions other than those performed by dilatation case Cross-Pet. App. A at A-7 n. 8.

in the Indiana case moved the District Court to modify its 1976 order and find the second trimester hospitalization requirement unconstitutional. The motion for modification was denied. The District Judge held that:

> *Roe* should not be given an interpretation which results in repeated relitigation of a statute's constitutionality. *Roe does not render the constitutionality of second trimester regulations subject to either the availability of abortions or the improvements in medical techniques and skills* [Emphasis added.]
>
> The test for determining the constitutionality of statutes regulating second trimester abortions is not whether the statute has the statistically demonstrable result of decreasing maternal morbidity or mortality for specific groups of abortions. . . . [*T*]*he ultimate test is a broader test: whether the legislature acted reasonably in determining that the regulation would promote maternal health.* . . . A statutory regulation of second trimester abortions is constitutional if it was reasonable for the state to conclude that the regulations would promote maternal health. [Emphasis added.]

496 F. Supp. at 901-902.

The District Court decision cited above was summarily affirmed by this Court, *Gary-Northwest Indiana Women's Services, Inc.* v. *Orr*, 451 U.S. 934 (1981).

CONCLUSION

In *Roe* v. *Wade*, this Court developed and announced detailed guidelines for the structuring of abortion statutes. That case clearly permits States to impose a hospitalization requirement on second trimester abortions to insure pro-

tection of a woman's physical and mental health. There have been no startling advancements in medical science which justify eradication of the Virginia legislature's determination, following the guidance of this Court, that second trimester abortions must be performed in hospitals. This is particularly true in a State such as Virginia where properly equipped outpatient clinics may qualify as hospitals for the purpose of satisfying the hospitalization requirement.

In the case at bar, the Commonwealth's indictment informed Simopoulos of the elements of the crime. The prosecution introduced more than sufficient evidence to permit a rational trier of fact to find Simopoulos guilty beyond a reasonable doubt of unlawfully performing a second trimester abortion outside of a licensed hospital. At no time was the burden of proof impermissibly shifted to the defendant.

The Commonwealth respectfully submits that this Court should affirm the April 24, 1981 judgment and order of the Supreme Court of Virginia in this case, and, accordingly, the Commonwealth of Virginia prays for such relief.

Respectfully Submitted,

GERALD L. BALILES
Attorney General

WILLIAM G. BROADDUS
Chief Deputy Attorney General

THOMAS D. BAGWELL
JULIA KREBS-MARKRICH
Assistant Attorneys General

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Appellant's Reply Brief

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No. 81-185

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

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Appellant,

v.

COMMONWEALTH OF VIRGINIA,
Appellee.

Appeal From The Supreme Court Of Virginia

REPLY BRIEF FOR APPELLANT

ROY LUCAS, *Counsel of Record*
LUCAS & ASSOCIATES P.C.
Three Ten Constitution Avenue, N.E.
Washington, D.C. 20002
(202) 543-5115

WILLIAM P. MARSHALL
1515 Hague Avenue
St. Paul, MN. 55104

Of Counsel:
JOHN H. OBRION
BROWDER, RUSSELL, LITTLE,
MORRIS & BUTCHER
1200 Ross Building
Richmond, VA 23219

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REPLY BRIEF FOR APPELLANT

STATEMENT OF THE CASE

The Commonwealth statement omits many facts material to this appeal.

I. At no point in the trial did the Commonwealth identify or call any witness who could testify to the physical or mental condition of P.M. before the abortion, afterwards, or during the time in the motel. These included:

(1) P.M.'s prior physicians, who were unknown to the defense;

(2) P.M.'s parents who may have been familiar with her physical or mental condition;

(3) the physician who examined P.M. after the abortion;

(4) P.M.'s boyfriend who may have had knowledge of her condition before and after the saline injection.

The defendant had no access to those potential witnesses (except to subpoena the parents). The Commonwealth declined to identify or call any of them.

The Commonwealth never assumed the burden of producing evidence on the physical or mental condition of P.M. That is one reason the prosecution never produced any of the above witnesses.

The trial court also never addressed the relevance of P.M.'s physical or mental condition. That creates doubt about the role of the medical necessity question, if any, in the deliberations of the trial court.

From opening statement to verdict the Commonwealth and trial court both ignored the medical necessity question.

II. The Commonwealth made no serious attempt to present medical expert testimony on the causation question. The prosecutor called only one of the physicians involved in the autopsy. That physician, Dr. Wiecking, did not make any medical determination that saline caused the demise or expulsion of the fetus. (J.A. 238-239).

At no point does the Commonwealth brief examine the deficiencies in Dr. Wiecking's testimony. Yet, he was the sole prosecution witness on causation.

III. Finally, the prosecution did not call a single witness to support the constitutionality of its second trimester hospital requirement. Not until this Court did the Commonwealth mention its regulations on outpatient hospitals and abortion hospitals. The record, however, is

silent on the applicability of those regulations to Dr. Simopoulos. The record does not show if any outpatient hospitals exist in Virginia and, if so, whether they allow second trimester abortions. Further, the record is silent on the reasonableness of the regulations in the context of second trimester abortions. They appear burdensome in a facial sense, but Dr. Simopoulos had no opportunity to defend against the regulations at trial.

Significantly, the regulations may not even apply to Dr. Simopoulos. A letter to him from the Attorney General advised:

> [I]f you wish to perform this type of procedure, you must, in essence, build a hospital to do it. . . . [Y]our clinic-office cannot be licensed as a hospital. (Appendix, *infra*).

The Commonwealth has not even belatedly shown that its barriers to second trimester abortions are medically necessary and reasonably related to maternal health.

I. THE NECESSITY QUESTION

The Commonwealth brief (pp. 9-13) on Point I fails to deal with the Virginia Supreme Court's construction of the statute and the resulting problems under *Roe* v. *Wade*, 410 U.S. 113 (1973), *United States* v. *Vuitch*, 402 U.S. 62 (1971), *Mullaney* v. *Wilbur*, 421 U.S. 684 (1975), and *Sandstrom* v. *Montana*, 442 U.S. 510 (1979).[1] Moreover, the Commonwealth disregards the fact that neither the prosecutor nor the trial court showed any awareness that lack of medical necessity was a relevant consideration. The case was tried in chief (J.A. 208-209, 449-450) as

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[1] The Commonwealth brief nowhere cites *Mullaney* nor *Sandstrom*.

if proof of any intentional aboriton[2] satisfied the prosecution's case. The prosecutor, in closing, phrased the issue in language even more restrictive than the 1848 Virginia abortion statute:[3]

> The issue is whether or not under the law this Defendant used some means to destroy the unborn child . . . and thereby terminate the life of that child. (J.A. 449-450).

This was consistent with the Virginia Supreme Court position, taken from the earlier case of *Russo* v. *Commonwealth*, 207 Va. 251, 148 S.E.2d 820 (1966).

Under *Russo* and the decision below, all abortions in Virginia are now indictable, subject to the assertion by a defendant at trial of affirmative defenses. (J.S. 5a-6a).

This would not be the case in Virginia even under the 1848 Act. The necessity section there appears in the same paragraph as the definition of prohibited acts.

The *Russo* rule, applied below, cannot withstand the impact of *United States* v. *Vuitch* and *Roe* v. *Wade*, *supra*. It sweeps too broadly and allows a physician to be criminally prosecuted for any abortion. The physician must then "invoke" a defense before the prosecution is obligated to show any fact beyond that of the abortion.

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[2] The non-hospital, second trimester factors were not contested.

[3] VA ACTS tit. II, c. 3, § 9, at 96 (1848), states:

Any free person who shall . . . use . . . any instrument or other means with intent thereby to destroy the child . . . unless the same shall have been done to preserve the life of such woman, shall be punished . . .

The text is from Quay, *Justifiable Abortion*, 49 GEO. L.J. 395, 517 (1961).

Such a rule impacts severely on constitutionally protected conduct.

II. THE CAUSATION QUESTION

The Commonwealth brief (pp. 13-16) points to no medical evidence or report that the saline injection "caused" the eventual demise of the fetus 48 hours later. No mention is made of the sole Commonwealth medical expert who failed to make that determination. (J.A. 230-240). Nor does the Commonwealth acknowledge that the prosecutor at trial abandoned his line of questioning on causation when the medical examiner failed to respond. (J.A. 234-235). Instead, the Commonwealth recites only facts and circumstances that arouse its suspicions.

Three physicians and a detective attended the autopsy of the fetus. (J.A. 61). Not one came forward at trial to confirm a cause of death that would implicate Dr. Simopoulos.

The medical examiner's report itself suggested that the "manner of death was natural." (J.A. 237).[4] This was consistent with the autopsy finding that the "cord and placenta [were] grossly normal." (J.A. 316). A successful saline procedure would have damaged the placenta. (J.A. 33-34). As the 1976 ACOG Technical Bulletin offered by the Commonwealth points out, after a successful saline injection, "[t]he placenta becomes edematous, there is extensive necrosis . . ." (VA. ADDENDUM 80). The Commonwealth in this case, however, had a placenta that was "grossly normal." (J.A. 316).

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[4] The Commonwealth did not offer this report as evidence, nor did it offer a fetal death certificate which may have contained an entry as to cause of death.

The absence of expert medical testimony on causation will defeat a civil malpractice claim in Virginia. The recent exhaustive opinion of Fourth Circuit Judge Russell in a diversity case made that point clear. *Fitzgerald* v. *Manning*, 679 F.2d 341, 350-351 (4th Cir. 1982). As *Fitzgerald* states,

> in order to qualify on causation, the opinion testimony of the medical expert may not be stated in general terms but must be stated in terms of a "reasonable degree of medical certainty." *Crawford* v. *Quarterman*, 210 Va. 598, 172 S.E.2d 739, 744 (1970).

679 F.2d at 350.

The present case must be judged by stricter standards. It is a felony prosecution of a physician. Here, there was no medical expert proof of negligence, causation, nor injury to P.M.[5] This total absence of proof requires an outright reversal of the conviction.

III. THE CRIMINALIZATION OF NON-HOSPITAL SECOND TRIMESTER ABORTIONS

The Virginia Supreme Court construed the second trimester hospital requirement to apply "to all procedures performed during the entire process, including the means employed with intent to initiate the process." (J.S. 8a). As to the constitutional question, the Virginia court stated:

> Courts accord legislative enactments a presumption of constitutionality, and the burden rests upon those who question their validity to overcome the

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[5] The prosecutor repeatedly described the offense as "victimless." (J.A. 473, 474, 476, 477).

> presumption . . . [T]he defendant has not carried his burden . . . (J.S. 19a).

This restrictive interpretation and standard of review have not been justified by the brief for the Commonwealth. As *Roe*, *Carey*, and *McRae* show, the government must establish that its regulation is narrowly drawn to satisfy a compelling state interest. No such effort was made at trial nor in the belated submissions by the Commonwealth to this Court.

Standing

The Commonwealth attempts to confine this case to a narrow judgment on a 22 week saline injection procedure. That is not how the statute was written. It proscribes all non-hospital second trimester abortions, regardless of physician technique or specific week in pregnancy. Physicians such as Dr. Simopoulos see patients at all stages of the second trimester (14, 15, 16, 17, 18 weeks, etc). They use varying medical/surgical techniques. It would be burdensome to try each physician for each different technique at each week of the second trimester of pregnancy. The narrow concept of standing urged by the Commonwealth is subject to exception here. As Justice White stated in *Broadrick* v. *Oklahoma*, 413 U.S. 601, 611 (1973):

> One such exception is where individuals not parties to a particular suit stand to lose by its outcome and yet have no effective avenue of preserving their rights themselves. *See Eisenstadt* v. *Baird*, 405 U.S. 438, 444-446 (1972); *NAACP* v. *Alabama*, 357 U.S. 449 (1958).

The present case will affect untold hundreds of physicians and patients, On the standing question, cases such as *Eisenstadt* v. *Baird* and *NAACP* v. *Alabama*, *supra*, are controlling.

Medical Safety

The Commonwealth never offered its photographs of Dr. Simopoulos' well equipped clinic as evidence. Nor does their brief seriously contest the relative safety of his procedure. Moreover, documents submitted by the Commonwealth state that "[t]he [saline injection] procedure can be carried out in a standard treatment room environment."[6]

The Record shows that Dr. Simopoulos had a well-equipped facility and employed the safe slow-drip technique of saline instillation. One can infer from the Commonwealth's own submission (VA. ADDENDUM 80) that the usual risk of saline was at least "halved" with the type of procedure used by defendant.

Availability of Second Trimester Abortions in Virginia

The Commonwealth, for the first time on this appeal, submits an affidavit and statistics to contend that second trimester abortions[7] are available in Virginia.

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[6] ACOG Technical Bulletin, Feb. 1976, (VA. ADDENDUM 80).

[7] Without further study one cannot determine if induced and spontaneous abortions are lumped together in these materials. The 14 alleged second trimester abortions of Virginia Baptist Hospital suggest so.

The Commonwealth has not disputed the findings of several studies which investigated the availability and cost of abortion services. (Brief for Appellant at 31-34, n. 44, 46-49). One such study concluded that forty-six percent of women in need were unable to obtain abortions in Virginia. (VA. ADDENDUM 16). Another study found "abundant evidence that many women still find abortion services difficult or impossible to get because of the distance they live from the nearest provider, the cost, a lack of information on where and how to get an abortion and other restrictions." (VA. ADDENDUM 7). A

The 1979 figures show 110 second trimester abortions at Fairfax Hospital and 16 at Alexandria Hospital. (VA. ADDENDUM 51). They also show a token number at other sites that on their face are not hospitals (*i.e.*, Doctor's Office—16; Hillcrest Clinic—4). *Id.*

These small numbers cannot possibly meet the total need, and the Commonwealth has not suggested otherwise.

Outpatient Hospital Regulations

The Commonwealth places great emphasis on the argument, raised here for the first time, that Dr. Simopoulos should have obtained an outpatient hospital license. (Brief for Appellee, 8, 19, 23-25, 27, 29-31). This argument was not made to the trial court nor the Virginia Supreme Court. According to the argument, such a license would bring the clinic within the broad definition of "hospital" contained in VA. CODE § 32.1-123. In such a "hospital," second trimester abortions could be performed with impunity. The appeal of this argument is undermined, however, by certain problems which the Commonwealth has chosen to ignore. Contrary to the Commonwealth's assertions, whether such a license is available is far from clear.

Outpatient hospitals are defined as institutions "which primarily provide facilities for the performance of surgic-

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recently published survey found that the average clinic charge for a first trimester abortion was $190 while hospital charges average $735. The average cost of second trimester D & E abortions was $358 in clinics and $740 in hospitals. Hospital charges for saline abortions average $940. *See* Henshaw, *Freestanding Abortion Clinics*, 14 Family Planning Perspectives 248, 255 (1982).

al procedures on outpatients." Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977), Section 20.2.11 (VA. ADDENDUM 4). A physician's office is explicitly excluded from the hospital licensure statutes and regulations, unless the office is used principally for performing surgery. VA. CODE § 32.1-124(5). Surgery is nowhere defined. Whether Dr. Simopoulos' facility primarily or principally performs surgery is a question of fact which remains unresolved to this day. Thus, the conclusion that he could have obtained an outpatient hospital license lacks a factual basis.

Moreover, Dr. Simopoulos was informed by the Attorney General's office that "your clinic-office cannot be licensed as a hospital," and that "if you wish to perform this type of procedure [second trimester saline abortions], you must, in essence, build a hospital to do it."[8]

The Virginia courts were not given an opportunity to construe the hospital licensing statutes and regulations. According to the interpretation now offered by the Commonwealth, Parts I and II of the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977), (VA. ADDENDUM 8-28), would cover a surgical facility where second trimester abortions were performed. This is so even though Part III, governing, "outpatient hospitals performing abortions only," explicitly restrict abortions to the first trimester. Section 62.1.2

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[8] Letter from Assistant Attorney General reproduced in Appendix. Even if he could have obtained an outpatient hospital license to provide second trimester abortions at his Falls Church office, he would also be required to obtain a certificate of public need (CON). VA. CODE § 32. 1-102.1 *et seq*. This arduous process consumes several months and requires that a public hearing be held. § 32.1-102.6.

(VA. ADDENDUM 31).[9] A more plausible reading of these regulations is that outpatient hospitals which provide abortion services cannot provide second trimester abortions. Consequently, the second trimester hospital requirement leaves second trimester abortions in the type of facility commonly referred to as "hospital," *i.e.*, acute care, general hospitals.[10]

Lay people automatically assume that it is safer to perform second trimester abortions in hospitals and that only hospitals have the capability to deal with emergency

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[9] The Commonwealth maintains that the hospital requirement "is nothing more than statutory recognition of the medical fact that second trimester abortions may require certain technological support not necessary in the relatively safe first trimester abortions." (Brief of Appellee at 23-24). Ironically, Part III of the Rules and Regulation (covering first trimester outpatient hospitals only) requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations which do not appear in Part II. See e.g., Section 63.1.1(b) (Medical Director of first trimester abortion hospital must be "certified by the American Board of Obstetrics and Gynecology and have training and experience in performing pregnancy termination procedures."); Section 63.3 (Counseling program requirements more specific than Part II's Section 43.8.5); Section 64.2.5 (a) - (m); Section 64.4.4(2) and (3). Given these extensive regulations for first trimester abortion hospitals, the only way to require *more* "technological support" for second trimester abortions would be to restrict them to acute care, general hospitals.

[10] First trimester abortions are performed at Dr. Simopoulos' Falls Church office. Although the Commonwealth urges that he could have obtained an outpatient hospital license (under Parts I and II of the Rules and Regulations) to perform second trimester abortions there, it does not argue that he should have procured a hospital license under Part III to perform first trimester abortions. The obvious implication is that until now the Commonwealth has considered the Falls Church facility to be a physician's office beyond the reach of the hospital licensure regulations.

situations.[11] Overwhelming medical evidence illustrates the error of these assumptions. Many physicians and medical organizations have examined all relevant data and adopted the position that a second trimester hospital requirement has no sound medical justification. The amicus brief submitted by the American Medical Association, *et al.* in *Akron Center for Reproductive Health* v. *City of Akron*, Nos. 81-746 and 81-1172, stresses the burden which such a requirement imposes on a woman's ability to obtain a safe second trimester abortion and the complete absence of any discernible safety benefit. *Id.* at 17-30. A blanket hospitalization requirement:

> . . . is not reasonably related to maternal health because it lacks foundation in light of current medical practice and knowledge, because it locks physicians into outmoded standards of care, and because no evidence exists that it provides any incremental safety benefit beyond that already provided by state physician licensing requirements.

Id. at 28 (footnote omitted).

Listing all complications, no matter how rare or preventable, does not begin to address whether mandatory hospitalization is necessary to assure proper management of second trimester abortion patients. None of the "serious" complications mentioned by the Common-

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[11] The treatment room at Dr. Simopoulos' clinic is equipped like an operating room. (J.A. 21-22). It has excellent lighting, wall outlets for oxygen, suction apparatus, resuscitation equipment, defibrillators, an EKG machine, IV fluids, complete anesthesia equipment and drugs to be used in emergencies. (J.A. 21-22, 375-76). The outpatient surgical unit at Fairfax Hospital—where saline injections are done—has one examination table, a ceiling light and IV fluids. "It does not have any of the equipment which I mentioned earlier that I have at the clinic." (J.A. 377). Another medical expert testified the clinic was better equipped for the injection of saline than the treatment room at Fairfax Hospital. (J.A. 96).

justifies the hospital requirement. (Brief for Appellee at 21-24). Four medical experts testified that saline amniocentesis can be safely performed outside of a hospital. (J.A. 20, 98-99, 148, 374-75).

CONCLUSION

For the reasons set out, this Court should reverse the judgment of conviction of Dr. Simopoulos, hold the statute unconstitutional, and direct further proceedings to dismiss the indictment.

Respectfully Submitted:

Counsel of Record
ROY LUCAS,
LUCAS & ASSOCIATES P.C.
Three Ten Constitution Avenue, N.E.
Washington, D.C. 20002
Tel: (202) 543-5115
By: Roy Lucas
ROY LUCAS
WILLIAM P. MARSHALL
1515 Hague Avenue
St. Paul, MN. 55104
Attorneys for Appellant.

Of Counsel:
JOHN H. OBRION
BROWDER, RUSSELL, LITTLE,
MORRIS & BUTCHER
120C Ross Building
Richmond, VA. 23219

CHRIS SIMOPOULOS, M.D.
14416 JEFFERSON DAVIS HIGHWAY
P.O. BOX 12
WOODBRIDGE, VIRGINIA 22194

PHONE 491-3366 OR 550-9387

February 13, 1980

Mrs. Marilyn West
Bureau of Resources Development
1001 Madison Building
109 Governor Street
Richmond, Virginia 23219

Dear Mrs. West,

I would like to obtain a certificate of need which would enable me to do amniocentesis with instillation of 20% saline (salt injection), at my clinic-office facility on 916 West Broad Street, Falls Church.

This is the preliminary step of second trimester abortions. All patients will be instructed to return to a local hospital when labor contraction ensue in order to abort under medical supervision. The salt injection is a safe medical procedure and has been practiced in this country since 1970 on an outpatient basis.

Very *few* hospitals in Virginia allow second trimester abortions to be done within their confines. Those that do charge prohibitive fees, such as $500.00 as an initial down payment. Furthermore, I cannot find a *single* hosptial in Virginia that does not require parental consent for minors (unconstitutional). Thus, many of my patients - the young

and the poor - cannot exercise their constitutionally guaranteed right to a second trimester abortion.

I will be glad to discuss this matter with you in every detail if need be.

Thank you,

Chris Simopoulos, M.D., F.A.C.O.G.

CS/lk

COMMONWEALTH OF VIRGINIA

MARSHALL COLEMAN
ATTORNEY GENERAL

OFFICE OF THE ATTORNEY GENERAL
SUPREME COURT BUILDING
1101 EAST BROAD STREET
RICHMOND, VIRGINIA 23219
804-786-2071

March 5, 1980

Chris Simopoulos, M.D., F.A.C.O.G.
14416 Jefferson Davis Highway
P.O. Box 12
Woodbridge, Virginia 22194

Dear Dr. Simopoulos:

Mrs. West of the Bureau of Resources Development in the State Health Department has asked me to respond to your letter requesting a certificate of need to do amniocentesis as a preliminary step of second trimester abortion.

I am enclosing a copy of § 18.2-73 of the Code of Virginia (1950), as amended, which governs the performance of second trimester abortions. As you can see from this statute, such abortions must be performed in a hospital licensed by the State Department of Health or under the control of the State Board of Mental Health and Mental Retardation. Consequently, if you wish to perform this type of procedure, you must, in essence, build a hospital to do it. I presume that your office is the typical doctor's office and as such, that does not fall under the statutory definition of "hospital" as it is found in the hospital licen-

sure law. Accordingly, your clinic-office cannot be licensed as a hospital.

Your only recourse is to find a local hospital which is willing to perform second trimester abortions. With regard to hospitals which require parental consent for minors, I really cannot comment. That practice is within the realm of each individual hospital.

With kindest regards, I remain

Sincerely,

/s/ Robert T. Adams
ROBERT T. ADAMS
Assistant Attorney General

Attachment

cc: Marilyn H. West

4:26:142

Amicus Brief

1

Nos. 81-185; 81-746 and 81-1172

Office - Supreme Court, U.S.
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AUG 7 1982
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
Appellee.

CITY OF AKRON, *et al.*,
Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,
Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,
Petitioners,

—v.—

CITY OF AKRON, *et al.*,
Respondents.

MOTION FOR LEAVE TO FILE AND BRIEF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, *AMICUS CURIAE*

DAVID B. HOPKINS
PATRICIA E. HENNESSEY
Civil Liberties and Public Policy Program
Hampshire College
Amherst, Massachusetts 01002

Attorneys for Amicus Curiae

MOTION FOR LEAVE TO FILE

The American Public Health Association (APHA) hereby respectfully moves for leave to file the attached brief amicus curiae. Consent for the filing of this brief was obtained from the attorneys for Dr. Chris Simopoulos, the Akron Center for Reproductive Health, Inc., the City of Akron and Respondents Seguin and Black. The consent of the attorneys for the State of Virginia was requested but refused.

APHA is a national, nongovernmental organization established in 1872 with the objective of protecting and promoting personal and environmental health. APHA is the largest public health organization in the world, with a membership of

50,000, including fifty-one state and local affiliate organizations.

APHA was the first organization of health professionals in this country to recognize the detrimental consequences of illegality and inaccessibility of abortion to women. Prior to this Court's landmark rulings in 1973, and as early as 1968, APHA supported the principle that abortion should be a matter of choice for all women. Following the decisions of Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973) APHA urged their full implementation in every state in order to make abortion a matter of safe medical practice throughout the nation.

APHA has appeared as amicus in many other important health-related cases before this Court, including

Roe v. Wade, supra, Beal v. Doe, 432 U.S. 464 (1977) and Collautti v. Franklin, 439 U.S. 379 (1979). This Court extensively quoted APHA's "Standards for Abortion Services" in Roe v. Wade, 410 U.S. at 144-46. APHA has also appeared as amicus in numerous cases in federal and state courts, including at the District and Circuit Courts in Akron Center for Reproductive Health Care, Inc. v. City of Akron.

APHA's objective in the abortion field is to assure that safe abortion services are in fact readily accessible to all women, regardless of socio-economic status. It is APHA's position that second trimester abortions may be safely performed in qualified, non-hospital facilities. Based on that policy, and the medical

research which supports it, APHA believes that requirements of hospitalization for all second trimester abortions are not justifiable as necessary to preserve maternal health.

Because these cases raise important questions concerning state regulation of abortion services, amicus respectfully urges this Court to accept and file the enclosed brief amicus curiae.

Respectfully submitted,

David B. Hopkins

David B. Hopkins
Patricia E. Hennessey
Civil Liberties and
Public Policy Program
Hampshire College
Amherst, Massachusetts
10102

Attorneys for
Amicus Curiae

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Cases

Akron Center for Reproductive Health Inc. v. City of Akron et al, 651 F. 2d 1198 (6th Cir. 1981). 7,9,10.27

Bellotti v. Baird, 443 U.S. 622 (1979) . passim

Carey v. Population Services International, 431 U.S. 678 (1977). 3,34

Commonwealth v. Simopoulos, 221 Va. 1059 277 S.E. 2d 194 (va. 1980) 7

Doe v. Bolton, 410 U.S. 179 (1973) . . . 4,26,36,37

Harris v. McRae, 448 U.S. 297 (1980) . . 38

H.L. v. Matheson, 450 U.S. 398 (1981). . 25

Michael M. v. Superior Court of Sonoma County, 450 U.S. 464 (1981). 13

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976). . . . passim

Roe v. Wade, 410 U.S. 113 (1973) . . . . passim

Other Authorities

Alan Guttmacher Institute, Abortion Needs and Services, 1977-79 (1981). . 5,6,15

Alan Guttmacher Institute, 11 Million Teenagers, (1976) 15,20

Alan Guttmacher Institute, Teenage Pregnancy: The Problem That Hasn't Gone Away, (1981) 14,15

American College of Obstetricians and Gynecologists, Manual of Standards, (1982). 26

American Public Health Association, "The Right to Second Trimester Abortion" (No. 7907, Adopted Nov. 1979). 9,26

Bracken, M and S. Kasl, Delay in Seeking Induced Abortion: A Review and Theoretical Analysis, 121 American Journal of Obstetrics and Gynecology 1008 (1975) 11

Cates, W., "Abortion for Teenagers" in Abortion and Sterilization, 141 (Hodgson, J. ed. 1981). 14,16,19

Cates, W., The Hyde Amendment in Action, 246 Journal of the American Medical Association 1009 (1981) 38

Cates, W., Letter to W. McBeath, APHA, January 19, 1979. 30

Cates, W. and D. Grimes, "Morbidity and Mortality of Abortion in the United States" in Abortion and Sterilization, 155 (Hodgson, J. ed. 1981). 12

Other Authorities (cont'd)

Cates, W., K. Schultz, D. Grimes and C. Tyler, The Effect of Delay and Method Choice on the Risk of Abortion Morbidity, 9 Family Planning Perspectives 266 (1977) 11,13

The Earlier and Safer Applies to All Abortions, 10 Family Planning Perspectives 243 (1978) 12

Grimes, D. et al., Comparative Risk of Death From Legally Induced Abortion In Hospital and Non-Hospital Facilities, U.S. Dept. of Health, Education and Welfare, Center for Disease Control (1980). 28

Hanson, M., Abortion in Teenagers, 21 Clinical Obstetrics and Gynecology 1175 (1978) 17

Jaffe, F., B. Lindheim and P. Lee, Abortion Politics, (1981) 5,10

Klein, L., Antecedents of Teenage Pregnancy, 31 Clinical Obstetrics and Gynecology 1154 15

Ryan, G. and J. Schneider, Teenage Obstetric Complications, 21 Clinical Obstetrics and Gynecology 1191 (1978). 20

Shelton, J., E. Brann and K. Schulz, Abortion Utilization: Does Travel Distance Matter?, 8 Family Planning Perspectives 260 (1976) 17

Other Authorities (cont'd)

Tryer, L., Complications of Teenage Pregnancy, 21 Clinical Obstetrics and Gynecology 1135 (1978). 20

INTEREST OF AMICUS

The interest of amicus is set forth substantially in the foregoing motion. Amicus respectfully informs the Court that it is in full agreement with the discussion of issues contained in the brief filed by Planned Parenthood Federation of America in Akron Center for Reproductive Health Inc. v. City of Akron and Planned Parenthood of Kansas City Inc. v. Ashcroft. APHA has particular expertise and interest in the need for, cost of, and availability of heath care services, including abortion. Therefore, amicus submits this brief limited to the issue of second trimester hospitalization requirements and their effect on access to needed abortion services.

SUMMARY OF ARGUMENT

Abortion services are not available to every woman who needs them. Hospitals contribute to this unmet need by failing to offer abortion services, particularly second trimester abortions. Hospitalization requirements impose a burden on reproductive choice by restricting access to abortion and by making second trimester abortions more difficult and more costly to obtain. Teenagers suffer most from hospitalization requirements. Mature minors may effectively be denied the right, established by this court, to obtain a second trimester abortion without parental consent. Point IA-D.

Since 1973 medical knowledge and practice, evidenced by the policies and standards of the American Public Health Association and The American College of

Obstetricians and Gynecologists, has advanced to the point where second trimester abortions can be performed safely in clinics, with less delay and cost than in hospitals. Point IE.

Under previous rulings of this court including Roe v. Wade, 410 U.S. 113 (1973) Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) and Carey v. Population Services International, 431 U.S. 678 (1979) restrictions on abortion warrant strict judicial scrutiny. Point II.

ARGUMENT

I. STATE STATUTES AND LOCAL ORDINANCES WHICH REQUIRE ALL SECOND TRIMESTER ABORTIONS TO BE PERFORMED IN HOSPITALS SEVERELY RESTRICT ACCESS TO ABORTIONS SERVICES AND MAY ENDANGER WOMEN'S HEALTH.

A. There Is A Large Unmet Need For Second Trimester Abortion Services. Hospitalization Requirements Exacerbate That Need.

After this Court's decision of Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973), abortion became a legal medical procedure throughout the country. However, today, close to a decade after the decisions, abortion services are not available to every woman who needs them. The biggest area of unmet need is second trimester services. Hospitalization rquirements like those of Virginia and Akron, Ohio reduce the amount of second trimester services available to women.

Hospitals have not responded to this Court's decisions of Roe and Doe by integrat-

ing abortion into their programs of health care services. In 1978 only 29% of all short-term, general, non-Catholic hospitals performed any abortions at all. Only 20% of those hospitals performed more than 30 procedures per year. Alan Guttmacher Institute, Abortion Needs and Services 1977-79 at 36 (1981) [Hereinafter cited as AGI Abortion Needs. Most Abortions are performed in specialized, non-hospital facilities known as "free standing clinics." In 1978 there were approximately 533 such clinics in the United States. F. Jaffe, B. Lindheim and P. Lee, Abortion Politics 35 (1981) [Hereinafter cited as Jaffe, Abortion Politics] However, hospitals are not abdicating abortion services in favor of these clinics. Most of the 1,728 public and 2,185 private hospitals which provided no abortion services in 1978 were located in non-metropolitan areas where there were no other abortion facilities available. AGI, Abortion Needs at 36.

Even fewer perform second trimester procedures and the number is declining.[1] In 1978 only 39% of the hospitals which provided any abortion services performed second trimester procedures. In that year only 635 hospitals performed second trimester procedures, 90 fewer than the estimated number in 1977. AGI, Abortion Needs at 58. In contrast, where not precluded by law, the number of free standing clinics that perform second trimester abortion services is increasing. Id.

The two states represented in the cases at bar provide graphic examples of the unmet need for second trimester services. As the Sixth Circuit found, in Akron, Ohio in 1977, only two hospitals performed any second trimester abortions, and in those two hospitals only nine second trimester procedures were

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[1] The vast majority of all abortions are performed in the first trimester of pregnancy. In 1978 only 9% of all abortions were performed more than 12 weeks after the onset of the last menstrual period. AGI, Abortion Needs at 13.

performed in the entire year. The estimated need for second trimester abortions in Akron was approximately 600 (10% of the 6000 women who sought abortions at Akron clinics.) Akron Center for Reproductive Health Inc. v. City of Akron, 651 F.2d 1198, 1209 (6th Cir. 1981) Similarly, in northern Virginia, the site of Dr. Simopoulos' practice, only two hospitals perform any second trimester abortions. Commonwealth v. Simopoulos, 221 Va. 1059 277 S.E. 2d 194, 204 (Va. 1981). Clearly, hospitals are not meeting the existing need for second trimester abortion services. Statutes and ordinances which limit the performance of second trimester abortions to hospitals will exacerbate the significant problem of unmet need.

The availability of second trimester abortion was an important factor in ruling on the constitutionality of second trimester restrictions in Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 78-79 (1976):

> Those unappreciated or overlooked factors [unavailability of prostaglandin method in Missouri] place the state's decision to bar the use of saline in a completely different light. The State, through §9 would prohibit the use of a method which the record shows is the one most commonly used nationally by physicians after the first trimester and which is safer, with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth. Moreover, as a practical matter, it forces - woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed.
>
> As so viewed, particularly in the light of present unavailability - as demonstrated by the record - of the prostaglandin technique, the outright legislative proscription of saline fails as a reasonable regulation for the protection of maternal health. It comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting the vast majority of abortions after the first 12 weeks. As such, it does not withstand constitutional challenge.

As the Sixth Circuit recognized, when hospitals are the only source of second trimester abortion many women are unable to find services, or to pay for them, see Point I.B., infra. For these women there are three stark alternatives: carrying the

pregnancy to term, attempting self-abortions, or seeking an illegal abortion. Akron Center for Reproductive Health v. City of Akron, 651 F.2d at 1209. Each of these alternatives is more dangerous to the woman's health than second trimester abortion, the latter two far more dangerous.[2]

---

[2] The experience of APHA members reveals that a significant percentage of women seeking second trimester abortions do so because of an identified threat to their lives of health such as pregnancy at a very young age or involving a fetus with known, serious congenital abnormalities or disease. Continuation of pregnancy for these women presents a heightened risk to their physical and psychological health, and the inability to obtain needed second trimester abortion services can be devastating. See, APHA Resolution 7907, "The Right to Second Trimester Abortion" (1979).

B. The Cost of In-Hospital Second Trimester Procedures Far Exceeds That of Non-Hospital Services.

The cost of abortion services in a hospital always exceeds the cost of parallel services in a clinic. In 1976 the average charge for an outpatient, first trimester abortion in a hospital was $250 plus the physician's fee. In-patient procedures were, of course, far more costly. In contrast, the average total cost of a first trimester procedure at a clinic at that time was $185-235. Jaffe, Abortion Politics at 36.

For second trimester abortion services the difference in cost is more pronounced.[3]

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[3] The Sixth Circuit noted testimony that the cost of a second trimester abortion in a hospital ($850 to 900) was more than double that of a second trimester abortion in a clinic ($350 to 400) Akron Center for Reproductive Health v. City of Akron, 651 F.2d at 1209.

C. Hospitalization Requirements Result in Delay in Obtaining Abortion Services, Which Has A Proven Negative Effect on Health.

Hospital abortions are characterized by added cost, limited geographic accessibility and added procedural complexities (e.g. scheduling the surgical facilities and the physician). These factors may delay a woman obtaining services. Delay is one of the most important factors in the risk of abortion morbidity. "Our findings clearly demonstrate that any delay increases the risk to a pregnant woman who wishes an abortion." W. Cates, K. Schulz, D. Grimes and C. Tyler, The Effect of Delay and Method Choice on the Risk of Abortion Morbidity, 9 Family Planning Perspectives 266, 268 (1977) [Hereinafter cites as Cates, et al., The Effect of Delay] (emphasis in the original). See also M. Bracken and S. Kasl, Delay in Seeking Induced Abortion:

A Review and Theoretical Analysis, 121 American Journal of Obstetrics And Gynecology 1008 (1975).

Legal abortion, including second trimester abortion is a remarkably safe procedure. See, e.g. W. Cates and D. Grimes, "Morbidity and Mortality of Abortion in the United States" in Abortion and Sterilization 155 (J. Hodgson, et. 1981) [Hereinafter cited as Cates and Grimes "Morbidity and Mortality"]. However, a decade of experience with legal abortion throughout the United States has confirmed that the earlier an abortion is performed, the less the risk of morbidity or mortality. "[D]elays of any sort--whether administrative, medical or social increase the risk of complication." Id. at 159; The Earlier the Safer Applies to All Abortions 10 Family Planning Perspectives 243 (1978); Cates, et al.,

The Effect of Delay at 267-68.

Thus, hospitalization regulations may have a significantly adverse effect on the health of even those women who are ultimately able to obtain second trimester abortions in hospitals.

D. Hospitalization Requirements Pose Particular Problems for Pregnant Teenagers.

For young women, the need for second trimester abortions is most acute, and the consequences of inaccessibility of those services is most severe.

1. Teenagers Have a Greater Need for Second Trimester Abortions.

This court has found previously that the number of teenage pregnancies have increased dramatically over the last twenty years, and that teenagers are disproportionately more likely to seek abortions. Michael M. v. Superior Court of Sonomoa

County, 450 U.S. 464, 470-71 (1981). See also, W. Cates, "Abortion for Teenagers" in Abortion and Sterilization 141 (J. Hodgson ed. 1981) [Hereinafter cited as Cates, "Abortion for Teenagers".] Teenagers are more likely than women in their 20's to need second trimester abortions. The younger the teenager, the greater incidence of second trimester abortion. "14 percent of abortions obtained by girls younger than 14 are performed at 16 weeks gestation or later, compared to just 7 percent of abortions among those aged 15-19 and 4 percent of abortion among women aged 20-24." Alan Guttmacher Institute, Teenage Pregnancy: The Problem That Hasn't Gone Away 55 (1981) [Hereinafter cited as AGI, Teenage Pregnancy] 52 percent of abortions obtained by girls under 14 are performed from 9 to 15 weeks gestation. Id.

The reasons teenagers often do not obtain abortions until midtrimester are varied. Lack of access to abortion services is a major cause. Id., L. Klein, Antecedents of Teenage Pregnancy 21 Clinical Obtetrics and Gynecology 1151, 1154 (1978); Cates, "Abortions for Teenagers" at 144. Another frequently cited factor in causing delay is the failure to recognize or suspect pregnancy, often due to a lack of understanding of the facts of reproduction. L. Klein, supra at 1154; Alan Guttmacher Institute, 11 Million Teenagers 30 (1976) [Hereinafter cited as AGI, 11 Million Teenagers.] For some young teenagers, irregular menstrual cycles make pregnancy detection difficult. AGI, Teenage Pregnancy at 56. In addition, many teenagers, faced with an unplanned pregnancy, and without the resources or skills of older women to cope with such a crisis,

psychologically deny the fact of pregnancy, often until anatomical changes are obvious, well into the second trimester. Cates, "Abortions for Teenagers" at 144. Given the obstacles teenagers face in pregnancy detection and obtaining abortion services, it is clear that teenagers will continue to need second trimester services:

> [T]he problem of late abortions, especially to teenagers, will not be significantly influenced by public health interventions. Thus, continued efforts are needed to make late abortion procedures safer, cheaper, more available, and more acceptable to women undergoing them.

Id. at 145

2. Hospitalization Requirements Create A Special Burden for Young Women.

The three consequences of hospitalization requirements--added cost, travel and delay--are particularly burdensome for teenagers. The methods of fundraising available to most teenagers are unlikely

to be sufficient to raise the $800 to 1,000 needed for an in-patient second trimester abortion. The lack of Medicaid funds for abortion in most states further complicates a teenager's problem. Most teenagers are dependent on their parents, partners, or public funds to pay for their abortions. See M. Hanson, Abortion in Teenagers, 21 Clinical Obstetrics and Gynecology 1175, 1179 (1978) (Young teenagers try to earn money for abortion through babysitting, resulting in delay.)

Research indicates that "the farther a woman has to travel to obtain an abortion, the less likely she is to have one." J. Shelton, E. Brann and K. Schultz, Abortion Utilization: Does Travel Distance Matter? 8 Family Planning Perspectives 260, 262 (1976). In that study, the effect of travel distance was most pronounced for black teenagers. Id. For young teenagers,

arranging travel outside one's own community is particularly difficult. The cost of travel adds further to the extremely high cost of obtaining second trimester abortions.

Since a large number of teenagers do not seek abortion services until well into the second trimester, further delay resulting from the limited availability of hospital services or hospital procedures will have the effect of advancing the abortion into a stage of significantly greater risk and for some, preclude abortion altogether.

3. The Consequences of Being Unable to Obtain a Second Trimester Abortion are Devastating to Teenagers.

Unintended pregnancy is frequently a severe physical, psychological and emotional crisis in the life of a teenager. "There are few situations in which denying a minor the right to make an

important decision will have consequences so grave and indellible." Bellotti v. Baird, 443 U.S. 622, 642 (1979). The gravity is equal when a teenager is unable, by reason of a state or local law to effectuate that decision.

For teenagers abortion, including second trimester abortion is safer than childbirth. "Teenagers have a lower death-to-case rate than older women after a legally induced abortion", even accounting for the disproportionate number of second trimester procedures obtained by teenagers. Cates, Abortions for Teenagers at 146. The risk of death from pregnancy continuation for teenagers is at least five times that of pregnancy termination. Id.

Teenagers, especially young teenagers, are at great risk in pregnancy. Fatal complications of pregnancy are 60 percent more likely for a girl under 15 than for a

woman 20-24, and 13 percent more likely between the ages of 15 and 19. AGI, 11 Million Teenagers at 23; L. Tryer, Complications of Teenage Pregnancy, 21 Clinical Obstetrics and Gynecology 1135 (1978). "Studies have shown that teenagers have a greater incidence of toxemia, abrupto placentae and cephalopelvic disproportion in pregnancy." G. Ryan and J. Schneider, Teenage Obstetric Complications, 21 Clinical Obstetrics and Gynecology 1191 (1978).[4]

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[4] Amicus does not suggest that all teenage pregnancies ought to be terminated. "Recent studies indicate that good prenatal care and attention to the psychosocial and economic problems of pregnancy reduced perinatal death and complication rates for pregnant teenagers." G. Ryan and J. Schneider, supra, at 1191. For those teenagers who wanted but could not obtain second trimester abortion services such good prenatal care and concern is not likely. In addition, the stress of the unwanted pregnancy and inability to obtain an abortion add further physical and psychological risk to the pregnancy.
(footnote continued)

4. Hospitalization Requirements May Have the Effect of Denying Minors the Right to Obtain Abortion Without Parental Consent.

In addition to the burdens on access caused by the cost, travel and delay, hospitalization requirements may pose an acute problem of constitutional dimensions for minor women--the inability to obtain an abortion without parental consent. It is not unusual for hospitals, like those of Northern Virginia, not to admit or treat minor women without parental consent.[5]

(footnote continued)

It is inevitable, therefore, that teenagers who are unable to obtain second trimester abortions will have pregnancies marked by a much heightened risk of health damage or death.

[5] Amicus does not address in this brief the validity of direct parental notice or consent statutes or provisions such as Secs. 1870.05(A) and 1870.05(B) of the "Akron Ordinance."

This court has recognized that minors as well as adults are protected by the Constitution, specifically that they enjoy a right of privacy. In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 74 (1976) this court held that a state could not lawfully authorize an absolute parental veto over the decision of a minor to terminate her pregnancy. After the Danforth decision, this court has examined a number of statutes relating to minors and abortion. The court has held that states which seek to require parental consent for abortion "must provide an alternative procedure whereby authorization for the abortion can be obtained without first consulting a parent." Bellotti v. Baird, 443 U.S. 622, 643 (1979) Further, in such procedures if a "pregnant minor shows (1) that she is mature enough and well enough informed to make her abortion

decision in consultation with her physician independently of her parents wishes or (2) that even if she is not able to make this decision independently, that the desired abortion would be in her best interests" 443 U.S. at 643-44, the minor's choice must be effected.

In Bellotti v. Baird, 443 U.S. at 642 this court stated:

> The abortion decision differs in important ways from other decisions that may be made during minority. The need to preserve the constitutional right and the unique nature of the abortion decision, especially when made by a minor, require a state to act with particular sensitivity when it legislates to foster parental involvement in this matter.

Even if it would be permissible or appropriate to require parental consent for all other medical or surgical procedures in a hospital, "the unique nature and consequences of the abortion decision make it inappropriate" to allow such blanket consent

requirements. Bellotti v. Baird, 443 U.S. at 643.

This court has recognized that "many parents hold strong views on the subject of abortion and young, pregnant minors, especially those living at home, are particularly vulnerable to their parents' efforts to obstruct both an abortion and their access to court." Bellotti v. Baird, 443 U.S. at 647 Clearly the same holds true when a minor needs access to a hospital for a second trimester abortion.

By refusing to consent to hospital admission parents could exercise an absolute veto over a minor's decision to terminate a pregnancy in the second trimester. Hospitalization regulations like the ones at issue would have the effect of doing indirectly what this court has repeatedly held a state may not do

directly--require all minors to obtain parental consent prior to obtaining a second trimester abortion. Planned Parenthood of Central Missouri v. Danforth, supra; Belloti v. Baird, supra. See also H. L. v. Matheson, 450 U.S. 398 (1981).

E. Recent Evidence From Medical Associations Finds That Hospitalization Requirements Are Not Justifiable as Necessary for the Preservation of Maternal Health.

As noted by this court in Roe v. Wade, 410 U.S. at 145, in 1970, APHA's first Recommendations on Abortion Services contained a recommendation that second trimester procedures be performed in hospitals. That recommendation was based on the limited research available, which was in turn based on the limited number of legal abortions performed in the 1960's. In 1979 APHA revised its position that all second trimester abortions should

be done in hospitals on an in-patient basis. This change is reflected in the APHA Resolution 7907, "The Right to Second Trimester Abortion" (Adopted November 1979).

Recently the American College of Obstetricians and Gynecologists (ACOG) revised its 1974 Manual of Standards and approved the performance of early second trimester abortions in clinics' 1982 ACOG Manual of Standards. These policy revisions are based on research and practice subsequent to 1973, and thus were not available to either APHA or to this Court at the time Roe v. Wade, supra, and Doe v. Bolton, supra, were decided.[6]

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[6] The City of Akron has relied heavily on the 1974 ACOG standard throughout this litigation, in an attempt to satisfy its burden, as defined by this court in Planned Parenthood of Central

(footnote continued)

In Roe v. Wade, 410 U.S. at 163 this court recognized that permissible state regulation of abortion to protect maternal health must be measured "in the light of present medical knowledge." This recognition of the advancing state of medical knowledge, treatment, and practice in the field of pregnancy is critical to the consideration of challenges to second trimester hospitalization requirements.

(footnote continued)

Missouri v. Danforth, 428 U.S. 52, 77-78, n.12 (1976). That burden requires Akron as the proponent of a restriction on access to establish facts which would show that the hospitalization requirement is sufficiently related to the state's legitimate interest in women's health. Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198, 1208 (6th Cir. 1981)

Up-to-date medical data from APHA and ACOG has informed this court's decisions in previous cases, particularly on the issues of abortion safety and the relative risks of childbirth and abortion. See Roe v. Wade, 410 U.S. at 163, Planned Parenthood of Central Missouri v. Danforth, 428 U.S. at 76-9.

While there are no published studies presently available that compare the safety of hospital and non-hospital abortions in the second trimester, the U.S. Department of Health and Human Services (formerly the Department of Health, Education and Welfare) has researched the comparative risk of death for hospital and non-hospital abortions at twelve weeks or less. This study revealed no major differences between the risks of death in the two types of institutions. D. Grimes et al., Comparative Risk of Death from Legally Induced Abortion in Hospital

and Non-Hospital Facilities, U.S. Department of Health, Education and Welfare, Center for Disease Control (1980). The results of this study have significance for midtrimester procedures in that the causes of death or complications for second trimester abortions are similar to those for first trimester abortions. If non-hospital facilities, therefore, meet adequate minimum standards[6] for dealing with the complications which may occur with second trimester abortions, there is no longer any reason to believe that the hospital setting is safer.

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[6] Amicus supports the National Abortion Federation and Planned Parenthood standards for non-hospital abortion facilities as constituting "minimum standards."

As Dr. Willard Cates, an expert on the medical consequences of abortion and childbirth, and for a number of years the head of the Abortion Surveillance Unit of the Center for Disease Control stated in connection with the formulation of APHA policy:

> I do not favor any proposed legislation limiting abortions performed after 12 weeks' gestation to hospital in-patients. Rather, experienced clinicians should be allowed to cautiously raise the gestational age threshold for abortions performed in free standing clinics. This will serve to minimize the inconvenience and costs of the procedure, and in some instances, will increase the availability of legal abortion who would be denied such services if it was required that they be performed in hospitals.

(Letter from Dr. Willard Cates to Dr. William McBeath, Executive Director, APHA, January 19, 1979).

Medical evidence is growing and consistent that second trimester procedures can be performed in clinics more safely

with less delay and less cost than previously. Each of these factors has a significant correlation to maternal health. Statutes and ordinances, like the ones at issue require that all second trimester procedures be performed in more expensive, less accessible hospitals. As such, they fly in the face of the policies of medical associations, and the body of medical fact which informs those policies.

II. THE COURT MUST EXAMINE THESE REGULATIONS WITH STRICT SCRUTINY BECAUSE THEY IMPOSE A RESTRICTION ON A FUNDAMENTAL RIGHT.

Amicus submits that the statute and ordinance at issue in these cases warrant strict judicial scrutiny because of the important constitutional right involved. In Roe v. Wade, 410 U.S. 113 (1973), this court held that in the second trimester the state may have a

compelling interest in protecting health which justifies regulations to promote maternal health. This ruling was predicated on the Court's finding that, at that time, 1973, second trimester abortions were as dangerous as childbirth

> With respect to the State's important and legitimate interest in the health of the mother, the "compelling" point, in the light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now established medical fact, ... that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Roe v. Wade, 410 U.S. at 163. (emphasis added)

Because advances in the abortion field have made the procedures safer than childbirth, it is the position of amicus that there is no longer the same reason

for second trimester regulations. Assuming arguendo, however, that the state may lawfully regulate second trimester abortions, the regulation at issue must fall under the standards set by this court in Roe v. Wade, supra, Planned Parenthood of Central Missouri v. Danforth, supra, and subsequent decisions. In Planned Parenthood this court specifically addressed the question of whether a Missouri second trimester restriction on saline abortions, the method then most commonly used in the second trimester was in fact "reasonably related to maternal health", and concluded that, far from promoting a woman's health, the restriction "forc[ed] a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." 428 U.S. at 79.

Medical evidence amassed since 1976 strongly indicates that blanket hospitalization requirements for second trimester abortions have the same effect, by prohibiting earlier, safe, less expensive second trimester abortions in clinics.

Amicus urges this court to make its own analysis of the medical evidence as it has done in the past, in judging whether in light of current medical facts, a hospitalization requirement for all second trimester abortions is reasonably related to maternal health. See Planned Parenthood of Central Missouri v. Danforth, 428 U.S. at 77.

In Carey v. Population Services International, 431 U.S. 678 (1979) this court clearly stated that regulations which impede access to a reproductive right are to be judged under the same strict standard as those regulations

which prohibit the exercise of the right entirely:

> the same test must be applied to regulations that burden an individual's right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision as is applied to statutes that prohibit the decision entirely.

431 U.S. at 688.

III. THE STATUTE AND ORDINANCE SINGLE OUT ABORTION FOR DIFFERENT TREATMENT IN MEDICAL REGULATION.

Second trimester abortion is the only procedure which the state of Virginia requires to be done in a hospital. Similarly, no medical procedure other than second trimester abortion is the subject of an Akron ordinance limiting performance to a hospital. These regulations, by prohibiting a medical practice, i.e. second trimester abortion in a clinic, which may be safer than the medical practice presecribed by the regulation, i.e. second trimester abortion in a hospital, unnecessarily and unwisely constrain physicians' exercise of their best medical judgment. This court has recognized that the physician's judgment is a strong safeguard of maternal health. See Doe v. Bolton, 410 U.S.

at 192, 195, 197; Planned Parenthood of Central Missouri v. Danforth, 428 U.S. at 77-79.

APHA policy recognizes that second trimester abortions, like the issue of Medicaid funding for abortions, is a favorite target of those who are politically opposed to abortion. APHA Policy No. 7907 "The Right to Second Trimester Abortion" (1979). Statutes and ordinances which single out abortion for unreasonable and unwarranted regulation dissuade doctors from performing abortion.[8] Further, such unwarranted and unreasonable restrictions have the effect of stigmatizing doctors who do perform second trimester abortions. As a consequence, fewer

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8 The experience of the restriction of federal funds for abortion is illustrative of the response by doctors

(footnote continued)

doctors will perform second trimester abortions, thus further limiting the availability of needed abortion services. Given the special risks of pregnancy in the Medicaid eligible population, particularly among teenagers (see Point I.D, supra), Amicus strongly believes that the number of abortions which would have qualified for federal funding would have exceeded 1% of the previous total.

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and hospitals to politically motivated administrative restrictions on medical treatment. The Hyde Amendment prohibited Medicaid payment for abortions not necessary to save the life of the mother. The Hyde Amendment did not prohibit the performance of abortions. See Harris v. McRae, 448 U.S. 297 (1980). After the Hyde Amendment went into effect, less than 1% of the abortions previously performed for Medicaid eligible women were performed and submitted for funding. W. Cates The Hyde Amendment in Action, 246 Journal of the American Medical Association 1109 (1981).

Amicus suggests that, throughout the country, in those states not funding either voluntarily or under court order, doctors are simply refusing to perform or consider abortions for Medicaid elegible women due to the bureaucratic trouble of certification procedures and the fear that their certifications would receive extra-ordinary and unwarranted scrutiny by state or federal authorities.

CONCLUSION

For the foregoing reasons, the Court should hold that state statutes and local ordinances that require

hospitalization for all second trimester abortions are unconstitutional.

Respectfully submitted,

PATRICIA E. HENNESSEY
DAVID B. HOPKINS

Civil Liberties and Public Policy Program
Hampshire College
Amherst, Massachusetts 01002
(413) 549-4600

Attorneys for Amicus Curiae

Amicus Brief

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CHRIS SIMOPOULOS, M.D., FACOG,
Appellant,

v.

COMMONWEALTH OF VIRGINIA,
Appellee.

Appeal From The Supreme Court Of Virginia

BRIEF AMICUS CURIAE OF AMERICANS UNITED FOR LIFE IN SUPPORT OF APPELLEE, COMMONWEALTH OF VIRGINIA

DENNIS J. HORAN
VICTOR G. ROSENBLUM
PATRICK A. TRUEMAN
THOMAS J. MARZEN*
MAURA K. QUINLAN
Americans United for Life
Legal Defense Fund
230 N. Michigan #915
Chicago, IL 60601
312/263-5029

September 8, 1982

* Counsel of Record

UNITED STATES LAW PRINTING CO., CHICAGO, ILLINOIS 60618 (312) 525-6581

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Other Authorities

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Berger, Edelman & Kerenyi, *Oxytocin Administration Instillation-to-Abortion Time, and Morbidity Associated with Saline Instillation,* 121 Am. J. Obstet. & Gynecol. 941 (1975) 16

Cameron & Dayan, *Association of Brain Damage with Therapeutic Abortion Induced by Amniotic Fluid Replacement,* 5494 Brit. Med. J. 1010 (1966) 17

Centers for Disease Control, U.S. Dept. of Health and Human Services, *Abortion Surveillance 1978* (1980) 7, 8, 9

Cohen & Ballard, *Consumptive Coagulopathy Associated with Intra-amniotic Saline Instillation and the Effect of Intravenous Oxytocin,* 43 Obstet. & Gynecol. 300 (1974) 18

Csapo, *The Termination Of Pregnancy by the Intra-amniotic Injection of Hypertonic Saline,* in 1966-1967 Yearbook of Obstetrics and Gynecology (Greenhill ed. 1967) 18

Frost, *Death Following Intra-amniotic Injection of Hypertonic Saline in a Case of Hydatidiform Mole,* 101 Am. J. Obstet. & Gynecol. 342 (1968) 15

Gordon, *Cervicovaginal Fistula as a Result of Saline Abortion,* 112 Am. J. Obstet. & Gynecol. 578 (1972) 19

Kerenyi, Mandelman & Sherman, *Five Thousand Consecutive Saline Inductions,* 116 Am. J. Obstet. & Gynecol. 593 (1973) 16, 17

Kerenyi & Den, *Intra-amniotic Instillation of Saline and Prostaglandin for Midtrimester Abortion,* in Pregnancy Termination 254 (1979) 18

Lee, Hills & Brudenell, *Management of Abortion Complicated by Clostridium Welchii Infection and Acute Renal Failure,* 20 British J. Clin. Pract. 169 (1966) 15

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McDonald & Aaro, *Medical Complications of Induced Abortions*, 67 Southern Med. J. 560 (1974) 14

Messer, *Medical Indications for Pregnancy Interruption*, in Pregnancy Termination 303 (1979) 16

Sehgal, Parr & Haslett, *Clostridium Infection After Intra-amniotic Hypertonic Saline Injection for Induced Abortion*, 8 J. Reprod. Med. 67 (1972) 14, 15

Strum, Tade & Shires, *Post-abortal Septicemia Due to Clostridium Welchii Treatment With Exchange Transfusion*, 122 Archives Internal Med. 73 (1968) .. 15

Walton, *Immediate Morbidity on a Large Abortion Service*, N.Y. St. J. Med. 919 (April 15, 1972) 14, 16

U.S. National Center for Health Statistics, *Infant, Maternal, and Neonatal Mortality Ratings by Race: 1930 to 1978*, in Vital Statistics of the United States (Table No. 111) (1980) 7, 8

In the Supreme Court of the United States

OCTOBER TERM, 1982

No. 81-185

CHRIS SIMOPOULOS, M.D., FACOG,

Appellant,

v.

COMMONWEALTH OF VIRGINIA,

Appellee.

Appeal From The Supreme Court Of Virginia

BRIEF AMICUS CURIAE OF AMERICANS UNITED FOR LIFE IN SUPPORT OF APPELLEE, COMMONWEALTH OF VIRGINIA

INTEREST OF THE AMICUS CURIAE

Americans United for Life (AUL) is a national educational foundation organized to promote better understanding of the humanity and value of unborn human life, and to assure equal protection under law for all members of the human family regardless of age, health, or condition of dependency. The national office of Americans United for Life is located in Chicago, Illinois. AUL is supported by thousands of Americans from every state of the union.

Letters of consent to the filing of this Amicus Brief by both parties have been filed with the Clerk of the Court.

SUMMARY OF THE ARGUMENT

At least 22 States have enacted statutes or regulations that require hospitalization for abortions performed during the second trimester.

In *Roe* v. *Wade,* 410 U.S. 113, 163 (1973), this Court stated that a State has a "compelling interest" in maternal health during the second trimester because the rate of maternal mortality arising from abortion is greater than that arising from childbirth. Therefore, the Court continued, a State may regulate abortion in ways that *"reasonably relate"* to the preservation of maternal health. The Court did not adopt the "narrowly drawn" requirement typically applied in strict scrutiny analysis. Instead, it adopted the hybrid test set forth above.

According to the most recent national statistics, mortality arising from saline abortions exceeds mortality from childbirth. Therefore, the State has a "compelling interest" in maternal health. Moreover, because the maternal health risks from abortion increase as the pregnancy progresses and because hospitals are better equipped to handle

the complications of late-term abortions when they arise, mandatory hospitalization requirements are "reasonably relate[d]" to the preservation of maternal health. Thus, under the *Roe* test, the Virginia hospitalization requirement is constitutional as applied to Simopoulos. It serves the State's "compelling interest" in maternal health and "reasonably relates" to the preservation of maternal health.

This Court should adhere to the standards it announced in *Roe* for evaluating the constitutionality of post-first trimester regulation of abortion on behalf of maternal health. Members of this Court have often recognized a critical distinction between statutes designed to obstruct the free exercise of a fundamental right and those which seek to enhance the exercise of that fundamental right. In *Connecticut* v. *Menillo*, 423 U.S. 9, 10 (1975), this Court stated that the abortional right of *Roe* was a "right to an abortion . . . under safe, clinical conditions." When the State attempts to promote its compelling interest in maternal health by enacting laws that enhance maternal health through requirements that abortions be performed under safe conditions, then the "narrowly drawn" requirement is inappropriate. It would require statutes that recognize fine-line distinctions between individual differences in physician skills, clinic facilities, and patient circumstances that would be virtually impossible for the State to specify, much less administer. It would also transform the courts into medical review boards required to re-evaluate statutes with the publication of each new medical study.

Appellant's suggestion that the independent decisions of private hospitals to refuse to provide unrestricted post-first trimester abortion services can be imputed to the State by virtue of a law that merely requires that abortions be performed in hospitals is without merit. The independent

decisions of private hospitals are constitutionally irrelevant.

This Court's most recent decisions defining the limits of "state action" are clearly contrary to any claim of "state action" in such circumstances. The State can be held responsible for a private decision only when it exercises coercive power or provides significant encouragement. Hospitalization requirements neither coerce nor significantly encourage hospitals to restrict the provision of abortion services. Therefore, the decisions of private hospitals and the consequences that flow from those decisions may not be deemed to be those of the State or of its hospitalization requirement.

Finally, any claim that a State's "conscience clause" law effectively limits the availability of midtrimester abortion services must fail for similar reasons. The mere existence of such a law is not sufficient to justify holding the State responsible for conscience-based decisions of private individuals or institutions. A state law may not be stricken simply because private parties refuse to provide services that would otherwise be available.

The Virginia hospital requirement is, therefore, constitutional as applied to Simopoulos and should be upheld.

ARGUMENT

I.

INTRODUCTION

This brief addresses the question of whether Virginia's mandatory hospitalization requirement for second trimester abortions is constitutionally permissible. Although this Court specifically acknowledged the State's right to legislate in this manner in *Roe* v. *Wade*, 410 U.S. 113, 163 (1973), the Appellant here challenges the Virginia law under which he was convicted for performing a late-term saline abortion outside of a hospital.

Because maternal health risks from abortion increase as the pregnancy progresses, at least 23 States have adopted statutes or regulations that require hospitalization for abortions performed after the first trimester.[1]

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[1] Alabama Rules, Regulations & Standards for Abortion or Reproductive Health Centers §302.2; Cal. Health & Safety Code §25951 (West 1982); Conn. Pub. Health Code Regs. Sec. 19-13-D54; Del. Code Ann. tit. 24 §1790 (1980); Hawaii Rev. Stat. §453-16(a) (1976); Idaho Code §18-608 (1979); Ill. Rev. Stat. ch. 38 §81-24 (1982); Ky. Rev. Stat. Ann. §311.760(2) (Baldwin 1981); Mass. Gen. Laws Ann. ch. 112, §12 Q (West 1982); Mich. Admin. Code R. 325.3851 (1976); Mo. Ann. Stat. §188.025 (Vernon 1982); Mont. Code Ann. §50-20-109(1)(b) (1981); N.C. Gen. Stat. §14-45.1(b) (1981); North Carolina Regulation 10 NCAC 3E. 0101 (1980); N.D. Cent. Code §14-02:1-04(2) (1981); Or. Rev. Stat. §435.415 (1981); 18 Pa. Cons. Stat. §3209 (1982); Rhode Island Rules and Regulations for Termination of Pregnancy §603.1 (1973); S.D. Codified Laws Ann. §34-23A-4 (1977); Tenn. Code Ann. §39-301(e)(2) (1975); Utah Code Ann. §76-7-302(2) (1981); Va. Code §18.2-73 (1982); Wash. Rev. Code Ann. §39.02.070 (1979).

Thus, a large number of States, relying on this Court's decision in *Roe*, have pursued their compelling interest in the protection of maternal health through hospitalization requirements. These States concluded that hospitalization enhances maternal health because hospitals are better equipped to handle the complications of late-term abortions when they arise. Their conclusions comport with the rationale of *Roe* v. *Wade*, are based on sound medical evidence, and warrant judicial deference.

II.

UNDER THE ROE v. WADE STANDARD FOR TESTING ABORTION RELATED STATUTES FURTHERING MATERNAL HEALTH, THE VIRGINIA STATUTE IS CONSTITUTIONAL AS APPLIED TO SIMOPOULOS.

In *Roe* v. *Wade*, this Court specifically acknowledged the State's right to further its compelling interest in maternal health by requiring that second trimester abortions be performed in hospitals:

> It follows that, from and after [the end of the first trimester], a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.

410 U.S. 113, 163 (1973).

While requiring that the State have a "compelling interest" to regulate in this manner, the Court did not use

the "narrowly drawn" requirement typically applied in strict scrutiny analysis. Instead, it required only that the regulation be "reasonably relate[d] to the preservation and protection of maternal health." *Id.*

Hence, the Court adopted a hybrid test: the State must have a "compelling" reason for wishing to reach the "end" it seeks, yet its statute need only "reasonably relate" to that compelling interest. The "means" by which it seeks to protect its compelling interest need not be "narrowly drawn."

Under this test, the Virginia hospitalization requirement is certainly constitutional as applied to Simopoulos.[2] It serves a compelling interest in maternal health, and it is reasonably related to mitigating maternal health problems that may result from abortion.

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[2] *Simopoulos* v. *Virginia* is not a class action. A ruling on the constitutionality of the Virginia post-first trimester abortion hospitalization requirements must, therefore, be limited to the constitutionality of their application to the conduct of Simopoulos. "Embedded in the traditional rules governing constitutional adjudication is the principle that a person to whom a statute may be constitutionally applied will not be heard to challenge that statute on the grounds that it may conceivably be applied unconstitutionally to others, in other situations not before the Court." *Broadrick* v. *Oklahoma*, 413 U.S. 601, 610 (1973). *See H.L.* v. *Matheson*, 450 U.S. 398, 405-407 (1981) (unemancipated, immature minor lacks standing to challenge facially a state statute that requires parental notice for all minors, including mature and emancipated minors).

Justice Stevens would have permitted a facial challenge in *H.L.* v. *Matheson* because it was a class action in which the appellant represented all minor women. 450 U.S. at 420-421. (Stevens, J., concurring in the judgment). Since this case is *not* a class action, however, Simopoulos cannot facially challenge the Virginia hospitalization requirement even under Justice Stevens's rationale.

A.

Virginia Has A Compelling Interest in Maternal Health Because Maternal Mortality From Saline Abortion Exceeds Maternal Mortality From Childbirth.

In *Roe* v. *Wade*, this Court held that

> [w]ith respect to the State's important and legitimate interest in the health of the mother, the "compelling" point, in the light of present medical knowledge, is at approximately the end of the first trimester. This *is so because of the now-established medical fact . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth.*

410 U.S. 113, 163 (1973) (emphasis added).

Thus, the State's interest in maternal health becomes "compelling" when the maternal mortality rate arising from abortion is greater than the maternal mortality rate arising from childbirth.

According to the most recent available official national statistics, maternal mortality for saline abortion during the period of gestation at which Simopoulos induced the extrahospital saline abortion for which he was convicted exceeds maternal mortality for normal childbirth.

The most recently calculated official rate of maternal mortality arising from childbirth (that for 1978) is 9.6 deaths per 100,000 live births. U.S. National Center for Health Statistics, *Vital Statistics of the United States* (Table No. 111) (1980). The most recently calculated official rate of maternal mortality arising from the use of saline instillation (that for 1972-1978) is 13.9 deaths per 100,000 saline abortions. Centers for Disease Control, U.S. Dept. of Health and Human Services, *Abortion Sur-*

veillance 1978, at 49 (Table 23) (1980).[3] The average rate of maternal mortality arising from the use of saline instillation at 16-20 weeks of gestation—the time period at which Simopoulos estimated the pregnancy of the minor he aborted[4]—is 17.6 deaths per 100,000 saline abortions. *Id.* (Week-by-week saline abortion mortality rates are not indicated by the Centers for Disease Control report.)

Thus, "in light of present medical knowledge" (*Roe*, 410 U.S. at 163), the method of abortion used by Simopoulos, at the period of gestation when he used it, carries a

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[3] Separate figures for the saline maternal mortality rate for 1978 are not given. The average of the yearly maternal mortality rates arising from childbirth for the years 1972-1978 (the same years for which saline mortality statistics are available) is 13.5 deaths per 100,000 live births—still less than the 13.9 rate for post-first trimester saline instillation and significantly less than the 17.6 rate for the gestational period during which Simopoulos induced the abortion for which he was convicted. *See infra*, n. 4. (Calculation based on statistics from U.S. National Center for Health Statistics, *supra* p. 7, at Table 111.) Even if it were hypothesized that the mortality rate for saline instillation declined in the years from 1972 to 1978, it is important to note that the mortality rate from childbirth has steadily declined during the same period—from 18.8 in 1972 to 9.6 in 1978 (*id.*), a decline of 48.9%.

[4] Simopoulos's records indicated a five month pregnancy, Joint Appendix [hereinafter "J.A."] 249, the equivalent of 20 weeks. The minor he aborted told him she was "about 22 weeks pregnant" (J.A. 268) and the autopsy report on the fetus estimated a gestational age of 5½ months (J.A. 315) or 22 weeks. The average rate of maternal mortality arising from the use of saline instillation at 21 weeks of gestation or greater is 17.1 deaths per 100,000 saline abortions, Centers for Disease Control, *supra* p. 7, at 49 (Table 23) —which is, of course, greater than either 9.6 or 13.5, the rates of maternal mortality arising from childbirth for 1978 and for 1972-1978 respectively.

maternal mortality rate greater than that of childbirth.[5] It follows that, as applied to the circumstances of this case, the State's interest in maternal health is compelling.

B.

As Applied To Simopoulos, Virginia's Hospitalization Requirement Reasonably Relates To The Preservation And Protection Of Maternal Health.

1. The "Reasonable Relationship" To Maternal Health Test Established By Roe v. Wade Is Appropriate And Should Not Be Reversed.

Under *Roe*, when the State's interest in maternal health is compelling, "a State may regulate the abortion procedure to the extent that the regulation *reasonably relates* to the preservation and protection of maternal health." 410 U.S. at 163 (emphasis added). Despite this explicit formulation of the "means" branch of the test to be employed for laws enacted to protect maternal health, Simopoulos

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[5] The maternal mortality rate associated with all forms of abortion at 16-20 weeks is 15.2 deaths per 100,000 abortions. The average mortality rate for all forms of abortion for the weeks subsequent to the first trimester is also 15.2. Centers for Disease Control, *supra* p. 7, at 49 (Table 23). Both abortion mortality rates exceed comparable maternal mortality rates ascsociated with childbirth—whether the most recent rate (9.6 for 1978) or the average of the yearly rates for 1972-1978 (13.5).

The Brief for Appellant at 41 n. 73 cites two individual studies that use much smaller patient populations in an effort to claim that the mortality rate for saline instillation is 6.5 deaths per 100,000 saline abortions. Surely, Virginia may rely on official Centers for Disease Control statistics, which encompass the greater experience of the entire national population.

now urges upon this Court a requirement that such laws must be *"narrowly drawn."* Brief for Appellant at 35 (emphasis added).

Such a reversal of *Roe* v. *Wade* would be unwarranted.

As Justice Stevens wrote for the Court in *Jones* v. *Helms,* 101 S.Ct. 2434, 2443 (1981), "[If a law] does not infringe upon . . . fundamental rights . . . the State need not employ the least restrictive, or even the most effective or wisest, means to achieve its legitimate ends." A regulation that genuinely advances maternal health does not "infringe upon fundamental rights" because *Roe* v. *Wade* "recognized only [Roe's] right to an abortion under *safe, clinical conditions." Connecticut* v. *Menillo,* 423 U.S. 9, 10 (1975) (emphasis added) (upholding application of a criminal abortion statute against a nonphysician even in the first trimester).

Similarly, Justice Powell, writing for the Court in *San Antonio Independent Sch. District* v. *Rodriguez,* 411 U.S. 1, 17 (1973), noted the "critical distinction" between "legislation which 'deprived,' 'infringed,' or 'interfered' with the free exercise of some . . . fundamental personal right" and legislation "the thrust [of which] is affirmative and reformatory and, therefore, should be scrutinized under judicial principles sensitive to the nature of the State's efforts and to the rights reserved to the States under the Constitution." In their concurring opinion in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52, 90 (1976), Justices Powell and Stewart applied this concept to abortion-related legislation, noting the difference between provisions "aimed at thwarting a woman's decision to have an abortion" and those "aimed at ensuring that the abortion decision is made in a knowing, intelligent, and voluntary fashion" to explain the lower level of

scrutiny the Court employed in upholding Missouri statutory informed consent requirements.[6]

In *Widmar* v. *Vincent*, 102 S.Ct. 269, 279 n. 3 (1981), Justice Stevens, concurring in the judgment, aptly noted the disadvantages associated with the imposition of a "narrowly drawn" means test. Quoting Justice Blackman's concurrence in *Illinois Elections Bd.* v. *Socialist*

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[6] The Brief Amici Curiae of Certain Law Professors argues that "the right to decide to terminate a pregnancy and the right to effectuate that decision, require the vigorous protection from governmental intrusions that only strict scrutiny, applied to *every* direct interference or burden, affords." *Id.* at 44 (emphasis in original), citing *Schad* v. *Borough of Mount Ephraim*, 452 U.S. 61, 68 (1981). In *Schad*, the Court wrote, "[As] is most often the case, the standard of review is determined by the nature of the right assertedly threatened or violated rather than by the power being exercised or the specific limitation imposed." *Id.* But the amici law professors are wrong to imply that "the right to decide to terminate a pregnancy and the right to effectuate that decision" are coterminous with the constitutional "right assertedly threatened or violated." *"Roe* did not declare an unqualified 'constitutional right to an abortion.' . . . Rather the right protects the woman from *unduly burdensome* interference with her freedom to decide whether to terminate her pregnancy." *Maher* v. *Roe*, 432 U.S. 464, 474 (1977) (emphasis added). Among the qualifications of that right are that the abortion be "performed . . . under safe, clinical conditions," as *Menillo* made clear (423 U.S. at 10), and that "this important decision has in fact been made by the person constitutionally empowererd to do so," as made clear in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 66 (1976) (*quoting* the district court judge dissenting in part and concurring in part, 392 F.Supp. 1362, 1374 [1975]). It is wholly appropriate, therefore, for this Court to follow its precedents in *Roe, Jones* and *Rodrigues* establishing a lesser level of scrutiny for state regulations that are directed at the enhancement, rather than the impedence, of the exercise of a fundamental constitutional right.

Workers Party, 440 U.S. 173, 188-189 (1979), he observed that a requirement that a law use the "least drastic means" to achieve its end "is a slippery slope and also a signal of the result the Court has chosen to reach. A judge would be unimaginative indeed if he could not come up with something a little less 'drastic' or a little less 'restrictive' in almost any situation, and thereby enable himself to vote to strike legislation down."

A holding by this Court reversing *Roe* v. *Wade* by requiring regulations that genuinely further maternal health to be "narrowly drawn," to be neither "overinclusive" nor "underinclusive," and to use only the "least restrictive means" to achieve their ends would produce a chaotic situation. Women could conceivably undergo abortions performed by expert nonphysicians in relative safety. Thus, although contrary to this Court's holding in *Menillo*, under a "narrowly drawn" requirement the State would be compelled to permit expert nonphysicians to perform abortions. Similarly, whenever it established regulations to protect maternal health the State would be required to promulgate different standards for different physicians depending on their varying degrees of skill—perhaps continuing to require physicians of lesser ability to perform abortions in hospitals, while permitting more proficient physicians to perform them in clinics. The degree of the doctor's skill would dictate the degree to which his or her clinic could be required to be equipped. Moreover, each individual woman's physical condition would dictate the setting in which the State could specify that she must obtain an abortion—the State could require only that certain women in certain situations at certain stages of pregnancy must have their abortions performed in hospital settings or

by specialists.[7] Obviously, such fine distinctions would be virtually impossible for the State to specify, much less administer.

Furthermore, the extremely refined case-by-case analysis required by the "narrowly drawn" test would transform the courts into medical review boards, re-evaluating statutes with the publication of each new medical study, acting effectively as legislative committees or administrative hearing boards. Such a situation might perhaps be justified if the legislation at issue were based solely upon interests clearly adverse to the exercise of a fundamental constitutional right. But it would be perverse, counterproductive, and unjustified in the case of legislation genuinely designed to enhance the exercise of such a right.

Considerations of law and policy thus demand that when it has been established that an abortion law genuinely serves the State's interest in maternal health—an interest congruent with that of the pregnant woman—then the Court should apply the "reasonable relationship" test specified by *Roe* v. *Wade*, and not the "narrowly drawn" test suggested by Simopoulos, certain amici, and the

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[7] An example of the impossible rigor with which the "narrowly drawn" test can be applied is provided by the First Circuit's invalidation of abortion informed consent requirements partly on the ground that *some* of the women to whom information is required to be conveyed *might* already be aware of that information. *Planned Parenthood League of Massachusetts* v. *Bellotti*, 641 F.2d 1006, 1016 (1st Cir. 1981). The court apparently reasoned that unless the State somehow arranges simultaneously to provide each item of information to all those women who are not yet aware of it and to withhold each item from all those women who are already aware of it, its informed consent regulations are not "narrowly drawn." The court did not explain how the State might discover whether or not a woman is aware of the information without providing it to her in some form in the first place.

plaintiff in *Planned Parenthood Ass'n. of Missouri* v. *Ashcroft*, 655 F.2d 848 (8th Cir. 1981), *cert. granted*, 102 S.Ct. 2267 (1982).

2. The Virginia Hospitalization Requirement Meets The "Rational Relationship" Test.

At trial, Simopoulos's own witnesses testified that saline instillation has the potential for serious complications and that the full resources of a hospital can be advantageous in dealing with them. Dr. Harold Schulman noted that saline instillation can lead to blood clotting problems. "[B]ecause of the danger that's inherent in this whole process," Dr. Schulman sends his own saline patients to the hospital for their saline-induced labor. *Simopoulos* v. *Commonwealth*, 277 S.E.2d 194, 202-203 (1981). Another defense witness, Dr. Thomas Gressinger, testified that hypernatremia is a risk when saline is instilled too rapidly, and that the saline process "should be closely supervised." *Id.* at 203. Because a hospital "is set up for close supervision," he sends his own patients there. *Id.*

Major complications of saline amniocentesis abortion include coagulopathy, hemorrhage, transfusion, cervical and uterine rupture, seizures secondary to eclampsia, hysterotomy, hysterectomy, peritonitis, fever, nausea, vomiting, diarrhea, and retained placenta. McDonald & Aaro, *Medical Complications of Induced Abortions*, 67 Southern Med. J. 560 (1974); Walton, *Immediate Morbidity on a Large Abortion Service*, N.Y. State J. Med. 919 (April 15, 1972); Sehgal, Parr & Haslett, *Clostridium Infection After Intra-amniotic Hypertonic Saline Injection for Induced Abortion*, 8 J. Reprod. Med. 67 (1972).

Virginia does not require that post-first trimester abortions must be performed in a general hospital; an outpatient surgical hospital is sufficient to satisfy the statute. This requirement that late-term abortions must

be performed either in a general hospital or in an outpatient facility inspected and evaluated to ensure that it conforms to the Department of Public Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) is reasonably related to the protection of maternal health. Outpatient hospitals operated in accord with Virginia's Rules are better equipped to prevent, to identify, and to treat complications arising from saline abortions than a physician's office or unlicensed clinic.

One extremely serious complication of saline abortion is clostridium infection, which can be fatal within 24 to 48 hours. Sehgal, Parr & Haslett, *supra* p. 14; Strum, Tade & Shires, *Post-abortal Septicemia Due to Clostridium Welchii Treatment with Exchange Transfusion,* 122 Archives Internal Med. 73 (1968); Lee, Hills & Brudenell, *Management of Abortion Complicated by Clostridium Welchii Infection and Acute Renal Failure,* 20 British J. Clin. Pract. 169 (1966). Significant portions of the Virginia Regulations (§§41.2.5, 43.2.1, 43.2.2, 43.10.1, 43.11, 43.12.3, 43.12.5, 52.2.5, 52.2.6, 52.2.7, and 52.2.13) are designed to assure that outpatient surgical hospitals practice stringent infection control, including sterile processing, appropriate waste disposal and laundry practices, isolation of nonpotable water, and protection of the integrity of the operating suite.

Attempting a saline abortion without confirmation that the patient is pregnant rather than having a fibroid or hydatidiform mole can have fatal consequences. Frost, *Death Following Intra-amniotic Injection of Hypertonic Saline in a Case of Hydatidiform Mole,* 101 Am. J. Obstet. & Gynecol. 342 (1968). The outpatient surgical hospital licensing requirements provide for a pre-admission pregnancy test (§§43.6.2, 43.8.4 and, 64.1.3[a] and for sufficient time before starting the surgery to review the results of lab tests (§43.8.3).

Performance of a saline abortion is contraindicated on a woman with diabetes or renal disease. Walton, *supra* p. 14 at 920. Under Rules §§43.6.2 and 64.1.3(e), urinalysis for blood sugar and albumin is required before an abortion is begun, thus increasing the probability that these conditions will be identified before it is too late.

Hemorrhage is one of the complications of saline. Berger, Edelman & Kerenyi, *Oxytocin Administration Instillation-to-Abortion Time, and Morbidity Associated with Saline Instillation,* 121 Am. J. Obstet. & Gynecol. 941 (1975); Kerenyi, Mandelman & Sherman, *Five Thousand Consecutive Saline Inductions,* 116 Am. J. Obstet. & Gynecol. 593 (1973). Rules §§43.6.2 and 64.1.3(b) require an outpatient surgical hospital to make hemoglobin or hematocrit determinations before initiating instillation: a low blood count can contraindicate saline abortion because of the increased danger should an abortion-related hemorrhage occur.

More generally, §41.2.3 requires each outpatient surgical hospital to establish minimal criteria for evaluation of patients before admission. This assures that diagnostic screening will take place and that there will be some uniformity in the physical status of individuals prior to undergoing the abortion procedure.

Anesthesia complications are among the major problems of the abortion procedure. Messer, *Medical Indications for Pregnancy Interruption,* in Pregnancy Termination 303, 305 (1979) (Table 38-4). By insuring minimal standards of physician competency and that an experienced, licensed physician is present for monitoring functions during the administration of anesthetics and in the recovery period, Rules §§43.1.1 and 43.1.2 increase the probability that severe complications from anesthesia can be avoided or alleviated.

Another set of Rules relate to the early and accurate identification of complications. Rule §43.9.2 requires a minimum period in the recovery room of 60 minutes for each patient; Rule §43.9.4 requires that patients be released for discharge only by a physician; Rules §§43.9.3 and 42.2.3 require that a physician and a registered nurse be on the premises throughout operation and recovery, and that a licensed nurse trained in emergency procedures supervise the recovery room. During and following the abortion procedure complications such as hyper- or hypotension, bleeding, nausea, vomiting, confusional states or headaches could be reasonably monitored by the registered nurse on duty during the time the facility is in use. This would go a long way toward identifying and alleviating such complications. (Fever, which is not necessarily present immediately following the abortion procedure, is an important clinical sign of infection and would be detected during the recovery period through monitoring by a registered nurse.) The required one-hour recovery period is a reasonable and necessary minimum. Kerenyi, Mandelman & Sherman, *supra* p. 16, report, "One of the patients first developed shortness of breath and hypotension. In the absence of hemorrhage, the diagnosis of amniotic fluid embolism was entertained. Blood drawn subsequently confirmed hypofibrinaginemia. *Within an hour* she developed the clinical picture with nose and gum bleeding and uterine hemorrhage." (Emphasis added.)

The third and perhaps the most important set of Rules relate to the ability to treat complications when they do occur. One of the most serious complications associated with saline instillation, hypernatremia, can occur when the salt solution is injected not only into the amniotic sac, but also into maternal tissue close to a blood vessel. Cameron & Dayan, *Association of Brain Damage with Therapeutic Abortion Induced by Amniotic Fluid Replacement*, 5494 Br. Med. J. 1010 (1966).

Resultant hypernatremia can lead to convulsions, sometimes producing aspiration of stomach contents into the lungs and subsequent asphyxiation. Rule §43.51 provides for a suction apparatus to deal with this possibility. This condition and others leading to difficulty in breathing can be treated properly if the facility has the oxygen supplies required by §43.51. Similarly, hemorrhaging could produce cardiovascular collapse, necessitating the resuscitation equipment also required by §43.51.

These and other possibilities justify the Rules and Regulations (§§43.5.2 and 43.5.3) that require an outpatient surgical hospital to maintain a transfer agreement with a general hospital "capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice."

Disseminated intravascular coagulation (DIC) or coagulopathy is believed to occur at the rate of at least 3 per 1,000 cases in clinical practice. It has actually been found to occur in *every* saline abortion to some degree when complete coagulation profiles are performed in the laboratory. Kerenyi & Den, *Intra-amniotic Instillation of Saline and Prostaglandin for Midtrimester Abortion,* in Pregnancy Termination 254 (1979); Cohen & Ballard, *Consumptive Coagulopathy Associated With Intra-amniotic Saline Instillation and the Effect of Intravenous Oxytocin,* 43 Obstet. & Gynecol. 300 (1974). If sufficiently severe, coagulopathy may require blood transfusions and carefully monitored intravenous heparin necessitating rapid transfer to a general hospital.

A study by Csapo, *The Termination of Pregnancy by the Intra-amniotic Injection of Hypertonic Saline,* 1966-1967 Yearbook of Obstetrics and Gynecology (Greenhill ed. 1967), showed that the peak uterine pressure during saline induced abortion was sometimes greater than that

recorded during normal term delivery. This, combined with the fact that uterine contractions during saline abortion may be exaggerated, asynchronis or otherwise abnormal, makes it possible to develop such complications as uterine rupture and cervical vaginal fistula. Gordon, *Cervicovaginal Fistula as a Result of Saline Abortion*, 112 Am. J. Obstet. & Gynecol. 578 (1972). Such conditions mandate immediate laparotomy—surgery which must be done in a general hospital.

Thus, Virginia's requirement that late term abortions be performed only in a general hospital or in a facility meeting the qualifications of an outpatient surgical hospital as defined by the Rules is reasonably related to maternal health.

In *Planned Parenthood* v. *Danforth*, three members of the Court agreed that if two modes of abortion were available, then "the United States Constitution would not prevent the State legislature from outlawing the one it found to be the less safe *even though its conclusion might not reflect a unanimous consensus of informed medical opinion.*" *Id.* at 101-102 (Stevens, J., concurring in part and dissenting in part) (emphasis added); adopted by Justices Powell and Stewart, *id.* at 92 (concurring opinion). Although the testimony of the physicians called by the defendant at trial may demonstrate the absence of unanimous agreement in the medical profession that 20 week saline abortions should be confined to hospitals, there is certainly medical support for that view. Indeed, in the companion case of *Planned Parenthood* v. *Ashcroft*, the chief executive officer of plaintiff Reproductive Health Services testified that all post-first trimester abortions other than dilation and evacuation abortions should be performed in hospitals. *Planned Parenthood Ass'n* v. *Ashcroft*, 483 F.Supp. 679, 685 n. 8 (W.D. Mo. 1980).

In the words of Justice Stevens, the existence of a state's "compelling interest"—here the interest in ma-

ternal health—"compels a court, before holding a law unconstitutional, to give thoughtful attention to a legislative judgment that the law will serve that interest. . . ." *Caban* v. *Mohammed*, 441 U.S. 380, 402-403 n. 3 (1979) (Stevens, J., dissenting). This Court does not sit as a medical review board to determine which of contending medical opinions is most likely to be correct. "Although the constitutional principle at least requires a legitimate and relevant reason and . . . perhaps even a substantial reason, it does not require the reason to be one that a judge would accept if he were a legislator." *Id.* at 415.

Even if diverse medical opinion about the wisdom of consigning saline instillation abortions at 20 weeks of pregnancy to hospitals exists, therefore, the evidence of the dangers associated with saline abortion and the greater capacity of hospitals to deal with these dangers makes the Virginia hospitalization requirement one that "reasonably relates to the preservation and protection of maternal health" (*Roe*, 410 U.S. at 163) when applied to the facts of this case.

III.

CONSEQUENCES THAT FLOW FROM THE FAILURE OF HOSPITALS TO PROVIDE UNRESTRICTED POST-FIRST TRIMESTER ABORTION SERVICES ARE NOT THE RESULT OF "STATE ACTION" AND ARE, THEREFORE, CONSTITUTIONALLY IRRELEVANT.

Simopoulos suggests that when a state-imposed hospitalization requirement is coupled with a subsequent failure of private hospitals to provide abortion services, the "burden" imposed by statutory hospitalization requirements is transformed into what is tantamount to a state-imposed *prohibition* on post-first trimester abortions. Brief for Appellant, at 31, 33-34 (arguing that the Virginia law imposes a special "burden" on the right to

abortion and the right to travel because many Virginia hospitals do not provide unrestricted abortion services and some require parental consent). *See also Planned Parenthood* v. *Ashcroft,* 483 F.Supp. 679, 687-88 (W.D. Mo. 1980); *M.S.* v. *Edwards,* 488 F.Supp. 181, 194 (E.D. La. 1980). According to this line of reasoning, even if such hospitalization requirements reasonably relate to the State's interest in maternal health, they must be struck down.

This rationale is fatally defective under the "state action" decisions of this Court. The independent decisions of private hospitals to refuse to provide unrestricted post-first trimester abortion services cannot be imputed to the State by virtue of a law that merely requires that abortions must be performed in hospitals. For this reason, whether hospitals provide abortion services only under certain restrictions, such as parental consent—or, indeed, whether they provide any abortion services at all—are constitutionally irrelevant considerations.

State action analysis is also crucial to the proper resolution of the hospitalization requirements at stake in *Planned Parenthood* v. *Ashcroft* and *Akron Center for Reproductive Health* v. *City of Akron,* 651 F.2d 1198 (6th Cir. 1981), *cert. granted,* 102 S.Ct. 2266 (1982), as well as the waiting period requirement at issue in *Akron.* Lower courts have frequently held 24-hour and 48-hour waiting periods unconstitutional on the basis of holdings that the delay they place upon the effectuation of the abortion decision consists not only of the statutory period, but also of additional days added by private abortion clinics' scheduling methods or locations. For example, in *Women's Medical Center of Providence* v. *Roberts,* 530 F.Supp. 1136, 1146 (D. R.I. 1982), the court concluded, "Although a mere twenty-four hour delay by itself may

not increase the risk of an abortion to a statistically significant degree, . . . the mandatory wait may combine with other scheduling factors such as doctor availability, work commitments, or sick leave availability, to increase the actual waiting period to a week or more." *See also Planned Parenthood League of Massachusetts* v. *Bellotti*, 641 F.2d 1006, 1014 (1st Cir. 1981) ("combination of a woman's schedule and the schedule of her abortion clinic may often serve to produce 'a substantially longer delay' than [statutory period of] 24 hours"); *Charles* v. *Carey*, 627 F.2d 772, 785 (7th Cir. 1980) ("in light of other practical limitations on women's access to abortions . . . the 24 hour mandatory waiting period produces in many cases a substantially longer delay"); *Women's Services* v. *Thone*, 636 F.2d 206, 210 (8th Cir. 1980) ("only abortion clinics in Nebraska are in the Omaha area and, therefore, the waiting period would increase . . . the time necessary for an abortion, especially for women from western Nebraska"); *Leigh* v. *Olsen*, 497 F.Supp. 1340, 1347 (D. N.D. 1980) ("It does not appear that the 48 hour waiting period would cause a significant increase in morbidity but the risks . . . would be increased if . . . required to wait four days[;] [b]ecause [plaintiff's physician] does not work on weekends, a patient may have to wait four days, from Thursday to Monday, before the abortion is performed."); *M. S.* v. *Edwards*, 488 F.Supp. 181, 212 (E.D. La. 1980) (24-hour waiting period unconstitutional; "delays will be three to five days because of weekends and because some clinics are not open five days a week"); *Women's Community Health Center* v. *Cohen*, 477 F.Supp. 542, 550-51 (D. Me. 1981) ("mandatory 48-hour waiting period in practice will delay some abortions . . . perhaps as long as a week, because of scheduling difficulties at the abortion facility and in the patient's life").

Delays created by the operating schedules or the location of private clinics, or by women choosing abortions, cannot be fairly imputed to the State, however, for the purpose of determining the degree of burden created by such waiting period requirements.

Sound constitutional adjudication requires close attention to what consequences flow from "state action" and what consequences flow from unrelated private decisions and conduct. The former may be conceived as "burdens" on the right to abort, while the latter lack constitutional significance. Particularly close attention to this distinction is warranted in the present context since hospitalization requirements have typically been attacked as "burdensome" because of the limited abortion access that may result from *private* decisions to fail to provide abortion services.

A.

The Hospitalization Requirement Does Not Transform Hospitals' Actions Into State Actions.

The right to abortion arises under the Fourteenth Amendment (*Roe* v. *Wade*, 410 U.S. at 153), and the Fourteenth Amendment applies only as against the State. "That Amendment erects no shield against merely private conduct, however discriminatory or wrongful." *Shelley* v. *Kraemer*, 334 U.S. 1, 13 (1948). Thus, only "state actions" can be said to violate or "burden" the right to abort.

The independent decisions of hospitals to refuse to provide unrestricted abortion services are not the decisions of the State. They are *private* decisions. "[C]onstitutional standards are invoked only when it can be said that the State is responsible for the specific conduct . . . when . . . the complaining party seeks to hold the State liable for

actions of private parties." *Blum* v. *Yaretsky*, 102 S.Ct. 2777, 2786 (1982). Simopoulos maintains "the fact that the Commonwealth first channels all second trimester abortions into the hospitals, and then imposes felony sanctions on those who cannot or do not use the hospital," makes Virginia constitutionally accountable for the actions of hospitals that fail to make abortion unrestrictedly available. Jurisdictional Statement at 20. But in *Blum*, when the State of New York channelled all Medicaid patients seeking nursing home care through physicians who could determine whether such care was "medically necessary" and hence eligibile for Medicaid, this Court did not impute to the State the actions of the physicians in making such determinations. "We cannot say that the State, by requiring completion of a form [making a determination about medical necessity], is responsible for the physician's decision." *Blum*, 102 S.Ct. at 2787. *Accord Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163, 173 (1972) (State's issuance of liquor license to private club, coupled with state prohibition of the sale of liquor without a license, did not make club's refusal to serve black guest "state action").

"[T]he inquiry must be whether there is a sufficiently close nexus between the State and the challenged *action* . . . so that the *action* . . . may be fairly treated as that of the State itself." *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974) (emphasis added). Here, there is no nexus at all between a state statute prohibiting post-first trimester abortions outside of hospitals and the independent decision of hospitals not to perform abortions.

It follows, therefore, that neither the failure of hospitals to provide abortion services nor the consequences that flow from such failure may be imputed to a state law that requires hospitalization for abortion.

A ruling to the contrary would lead to extraordinary results. If requirements that post-first trimester abortions may be performed only in hospitals made decisions of hospitals not to perform abortions "state action," it would be equally true that the requirement that abortions at any stage of pregnancy may be performed only by physicians would make any private physician's refusal to perform an abortion "state action." This would lead to the striking of physician-performance requirements—although they have been upheld in *Roe*, 410 U.S. at 164, and in *Connecticut* v. *Menillo*, 423 U.S. at 10—in areas where many of the practicing physicians are anti-abortion just as Simopoulos contends in this case that state hospitalization requirements must be stricken in areas where hospitals fail to provide abortion services.

The prior decisions of this Court, however, preclude such results. "Our precedents indicate that a State normally can be held responsible for a private decision only when it has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State." *Blum*, 102 S.Ct. at 2786. But, obviously, post-first trimester hospitalization requirements neither coerce nor significantly encourage hospitals to refuse to provide unrestricted abortion services. Thus, the decisions of hospitals to fail to provide abortion services and the consequences that flow from these decisions may not be deemed to be those of the State or of a state hospitalization requirement.

The action of the Court in *Planned Parenthood* v. *Danforth*, 428 U.S. at 75-79, voiding a statutory ban on saline abortions partly because the alternative prostaglandin method of post-first trimester abortion was not available in Missouri, is not to the contrary. There is a fundamental distinction between the near impossibility of obtaining what the *Danforth* Court found to be only an experimental

technique—and thus effectively tantamount to a physically nonexistent technique—and whatever difficulty may be experienced in obtaining a physically possible technique that providers simply choose not to use. For the purposes of "state action" analysis, this difference is essentially one of causation. A state law that, in effect, prohibits abortion except when it is performed in a particular manner that is physically impossible is the direct and proximate cause of the resultant unavailability of abortions. But when a state law justifiably requires that abortions be performed in a particular manner that *is* physically possible and those with the capacity to perform it choose not to do so, then their choice introduces an intervening and supervening cause, and the resultant unavailability of abortions cannot be ascribed to the state law. When the impact on abortion availability follows directly from the law's interaction with the irreducible physical facts (as was the case with Missouri's ban on saline abortions), then the result may fairly be imputed to the State. When, however, the impact on abortion availability is wholly dependent on the separate decisions of private actors exercising independent volition (as is the case with Virginia's hospitalization requirement), then the result may not be imputed to the State.

It must be concluded, therefore, that the reasoning the *Danforth* Court applied to Missouri's saline ban has no application to this case. Since state laws that restrict abortion to hospitals do not require or even encourage hospitals to fail to provide abortion services, any "burdens" on the exercise of the right to abortion that might result from hospital decisions to abstain from abortion practices cannot be imputed to such hospitalization requirements. Consequences that flow from the failure of hospitals to provide abortion services are the result of private action, not "state action."

B.

The Virginia "Conscience Clause" Law Does Not Render Private Hospitals' Refusals To Provide Abortions Actions That May Be Imputed To The State.

Simopoulos argues that the hospitalization requirement "drastically limits" a Virginia woman's access to midtrimester abortion services because "[t]he Commonwealth also authorizes hospitals to prohibit performance of all abortions. Va. Code Sec. 18.2-75." Jurisdictional Statement at 15. The existence of a Virginia "conscience clause" law that protects individuals and the institutions they operate from being coerced to participate in an activity that may profoundly offend deeply held ethical beliefs does not, however, transform the conscience-based decisions of private individuals and the institutions they operate into "state action" that burdens the abortion right. "Mere approval of or acquiescence in the initiatives of a private party is not sufficient to justify holding the State responsible for those initiatives under the terms of the Fourteenth Amendment." *Blum*, 102 S.Ct. at 2786.

In *Jackson* v. *Metropolitan Edison* this Court considered a claim that a termination of electrical service by a private utility under rules specifically approved and authorized by the Pennsylvania Utility Commission constituted state action subject to review under the Fourteenth Amendment's due process clause. The Court squarely held that the State Commission's approval of the applicable utility termination rules "where the commission has not put its own weight on the side of the proposed practice by ordering it, does not transmute a practice initiated by the utility and approved by the commission into 'state action.' At most, the Commission's [action] amounted to no more than a determination that a Pennsylvania utility was authorized to employ such a practice if it so desired. [The private

party's] exercise of the choice allowed by law where the initiative comes from it and not from the State, does not make its action in doing so 'state action' for purposes of the Fourteenth Amendment." 419 U.S. at 357 (footnote omitted).

The situation in *Jackson* is precisely analogous to the Virginia conscience clause law, which in no way urges or compels any private individual or institution to choose to exercise the choice the statute authorizes.

Arguments that post-first trimester hospitalization requirements and "conscience clause" laws "prohibit" or "burden" exercise of the right to abortion because hospitals themselves fail to provide convenient, inexpensive, or expeditious abortion services must, therefore, be disregarded as constitutionally irrelevant. A state law may not be stricken simply because private parties willfully refuse to provide a service that would otherwise serve public health interests.

CONCLUSION

This Court should adhere to the standards it announced in *Roe* v. *Wade* for evaluating the constitutionality of post-first trimester state regulations of abortion on behalf of maternal health.

Because maternal mortality from saline instillation at the period in pregnancy when Simopoulos performed the abortion for which he was convicted exceeds maternal mortality from childbirth according to the most recent available official national statistics, Virginia's interest in maternal health is "compelling" under *Roe*. There are significant complications potentially associated with saline abortions and the requirements Virginia specifies for outpatient sur-

gical hospitals may reasonably be said to decrease the risk of the development of those complications or to increase the chance that they will be controlled if they do occur. Thus, the Virginia law that prohibited Simopoulos from performing a 20 week saline abortion outside such a licensed facility or a general hospital "reasonably relates to the preservation and protection of maternal health" (410 U.S. at 163) and is, therefore, constitutional under *Roe* v. *Wade*.

Since regulations that genuinely advance maternal health enhance rather than impede the liberty recognized in *Roe*, the Court should not overturn *Roe* and require that such regulations be "narrowly drawn." Nor should the Court, contrary to the principles of *Blum* v. *Yaretsky* and of its other "state action" precedents, impute to Virginia the independent decisions of private hospitals concerning whether or under what conditions to provide abortions.

Because the Virginia hospital requirement is constitutional under this Court's clearly articulated precedents, Simopoulos's conviction should be affirmed.

Respectfully submitted,

DENNIS J. HORAN
VICTOR G. ROSENBLUM
PATRICK A. TRUEMAN
THOMAS J. MARZEN*
MAURA K. QUINLAN
Americans United for Life
Legal Defense Fund
230 N. Michigan, Suite 915
Chicago, Illinois 60601
(312) 263-5029
Counsel for Amicus

September 8, 1982

* Counsel of Record

Steven R. Zielinski, M.D., was Medical Consultant for this brief.

Amicus Brief

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Nos. 81-185, 81-746 and 81-1172, 81-1255 and 81-1623

ION FILED
AUG 4 1982

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,

—v.—

CITY OF AKRON, et al.,
Defendants-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF AMICI CURIAE OF CERTAIN LAW PROFESSORS

(Names of Individual Amici appear within)

SUSAN FRELICH APPLETON
Washington University School of Law
St. Louis, MO. 63130
(314) 889-6449

PAUL BREST
Stanford Law School
Stanford, CA. 94305
(415) 497-3573

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,

Plaintiffs-Petitioners,

—v.—

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,

Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,

Defendants-Petitioners,

—v.—

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,

Plaintiffs-Respondents.

INDIVIDUAL AMICI

Richard L. Abel
Professor of Law
University of California at Los Angeles School of Law

Francis A. Allen
Sutherland Professor of Law
University of Michigan School of Law

Anthony G. Amsterdam
Professor of Law
New York University School of Law

Claudia Angelos
Clinical Assistant Professor of Law
New York University School of Law

Frank Askin
Professor of Law
Rutgers Law School

Paul Bender
Professor of Law
University of Pennsylvania Law School

Thomas Blumenthal
Clinical Law Teacher
Washington University School of Law

Richard Bonnie
Professor of Law
University of Virginia School of Law

Susan Bryant
Assistant Clinical Professor
Hofstra University School of Law

John M. Burkoff
Professor of Law
University of Pittsburgh School of Law

Janet M. Calvo
Assistant Clinical Professor of Law
New York University School of Law

Oscar G. Chase
Professor of Law
New York University School of Law

Patricia Dore
Associate Professor of Law
Florida State University
College of Law

John N. Drobak
Associate Professor of Law
Washington University School of Law

Thomas I. Emerson
Lines Professor of Law Emeritus
Yale Law School

Martha A. Field
Professor of Law
Harvard University Law School

Eleanor M. Fox
Professor of Law
New York University School of Law

Ann E. Freedman
Associate Professor of Law
Rutgers Law School

Lawrence A. Frolik
Professor of Law
University of Pittsburgh School of Law

Stephen Gillers
Professor of Law
New York University School of Law

Gary Goodpaster
Professor of Law
University of California at
Davis School of Law

Robert J. Goodwin
Clinical Law Teacher
Washington University School of Law

Jacob Hyman
Professor of Law Emeritus
Buffalo School of Law, S.U.N.Y.

Jonathan M. Hyman
Associate Professor of Law
Rutgers Law School

Louis A. Jacobs
Associate Professor of Law
Ohio State University College of Law

William C. Jones
Professor of Law
Washington University School of Law

Jane Kammerman
Clinical Professor
University of Minnesota Law School

James C. Kirby, Jr.
Professor of Law
University of Tennessee College of Law

John R. Kramer
Associate Dean and Professor
Georgetown University Law Center

Richard B. Kuhns
Professor of Law
University of Iowa College of Law

David P. Leonard
Assistant Professor of Law
Indiana University School of Law

Howard Lesnick
Professor of Law
C.U.N.Y. Law School

John Leubsdorf
Professor of Law
Boston University School of Law

Ronald M. Levin
Associate Professor of Law
Washington University School of Law

Daniel R. Mandelker
Stamper Professor of Law
Washington University School of Law

Pamela E. Mann
Staff Attorney, Constitutional
Litigation Clinic
Rutgers Law School

Robert B. McKay
Professor of Law
New York University School of Law

Alan Meisel
Professor of Law
University of Pittsburgh School of Law

Carrie Menkel-Meadow
Acting Professor of Law
University of California at Los
Angeles School of Law

Roy M. Mersky
Professor of Law
University of Texas Law School

Arthur S. Miller
Professor of Law Emeritus
George Washington University National
Law Center

Elliott Milstein
Professor of Law
American University,
Washington College of Law

Chester L. Mirsky
Professor of Law
New York University School of Law

Alice Morey
Assistant Clinical Professor
Hofstra University School of Law

Burt Neuborne
Professor of Law
New York University School of Law

Wade J. Newhouse
Professor of Law
S.U.N.Y. at Buffalo School of Law

Marcia O'Kelly
Associate Professor of Law
University of North Dakota
School of Law

John de J. Pemberton, Jr.
Professor of Law
University of San Francisco
School of Law

Michael J. Perry
Professor of Law
Ohio State University College of Law

Joan Pransky
Staff Attorney, Urban Legal Clinic
Rutgers Law School

Philip J. Prygoski
Associate Professor of Law
Thomas M. Cooley Law School

Louis Raveson
Assistant Professor of Law
Rutgers Law School

Steven Reiss
Assistant Professor of Law
New York University School of Law

Judith Resnik
Associate Professor of Law
University of Southern California
Law Center

David A.J. Richards
Professor of Law
New York University School of Law

Rhonda R. Rivera
Professor of Law
Ohio State University College of Law

Rand E. Rosenblatt
Professor of Law
Rutgers Law School

Patricia E. Rousseau
Assistant Professor of Law
Rutgers Law School

David Rudovsky
Instructor of Law
University of Pennsylvania Law School

Laura Sager
Associate Clinical Professor of Law
New York University School of Law

Elizabeth M. Schneider
Staff Attorney, Constitutional
Litigation Clinic
Rutgers Law School

Robert A. Sedler
Professor of Law
Wayne State University Law School

Herbert Semmel
Professor of Law
Antioch School of Law

Annamay T. Sheppard
Professor of Law
Rutgers Law School

Susan A. Short
Clinical Professor
University of Minnesota Law School

Eileen Silverstein
Professor of Law
University of Connecticut
School of Law

Robert H. Smith
Assistant Professor of Law
Boston College Law School

Edward V. Sparer
Professor of Law and Social Welfare
University of Pennsylvania Law School

Roy G. Spece, Jr.
Professor of Law
University of Arizona College of Law

Edward Steinman
Professor of Law
University of Santa Clara
School of Law

Dale Swihart
Professor of Law
Washington University School of Law

Nadine Taub
Professor of Law
Rutgers Law School

Karen Tokarz
Assistant Professor of Law
Washington University School of Law

Mark Tushnet
Professor of Law
Georgetown University Law Center

William W. Van Alstyne
Professor of Law
Duke University School of Law

Kathleen Waits
Assistant Professor
University of Florida, Spessard
L. Holland Law Center

Michael S. Wald
Professor of Law
Stanford Law School

Joan Wexler
Associate Professor of Law
New York University School of Law

Welsh S. White
Professor of Law
University of Pittsburgh School of Law

Robert Whitman
Professor of Law
University of Connecticut Law School

Wendy W. Williams
Assistant Professor of Law
Georgetown University Law Center

Steven J. Wisotsky
Professor of Law
Nova University Center for the
Study of Law

Diane L. Zimmerman
Associate Professor of Law
New York University School of Law

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Roe v. Wade, 410 U.S. 113 (1973) . . 1, 5, 6, 7, 8, 9, 10, 12, 13, 18, 20, 21, 22, 23, 24, 26, 27, 28, 32, 33, 34, 35, 36, 37, 38, 40, 46, 50, 52, 65

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Simopoulos v. Commonwealth, 277 S.E.2d 194 (Va. 1981), probable jurisdiction noted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (No. 81-185) . . . 37

Thomas v. Collins, 323 U.S. 516 (1945) . . . 44

Whalen v. Roe, 429 U.S. 589 (1977) . . . 6, 7, 31, 58

Widmar v. Vincent, 102 S.Ct. 269 (1981) . . 52

Williams v. Zbaraz, 448 U.S. 358 (1980) . . . 12

Other Authorities

Appleton, Beyond the Limits of Reproductive Choice: The Contributions of the Abortion-Funding Cases to Fundamental-Rights Analysis and to the Welfare-Rights Thesis, 81 Colum. L. Rev. 721 (1981) 50

Page

Gunther, The Supreme Court, 1971 Term--Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for Newer Equal Protection, 86 Harv. L. Rev. 1 (1972) 52

Note, Of Interests, Fundamental and Compelling: The Emerging Constitutional Balance, 57 B.U.L. Rev. 462 (1977) 47

Tribe, The Supreme Court, 1972 Term--Foreword: Toward a Model of Roles in the Due Process of Life and Law, 87 Harv. L. Rev. 1 (1973) 6, 46

Nos. 81-185, 81-746 and 81-1172,
81-1255 and 81-1623

In the
Supreme Court of the United States
October Term, 1982

Chris Simopoulos, M.D., FACOG,
Defendant-Appellant
v.
Commonwealth of Virginia,
State-Appellee

City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive Health,
Inc., et. al.,
Plaintiffs-Respondents

Akron Center for Reproductive Health,
Inc., et al.,
Plaintiffs-Petitioners
v.
City of Akron, et al.,
Defendants-Respondents

Planned Parenthood Association of
Kansas City, Missouri, Inc., et. al.,
Plaintiffs-Petitioners
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents

John L. Ashcroft, Attorney General of
the State of Missouri, et al.,
Defendants-Petitioners
v.
Planned Parenthood Association of
Kansas City, Missouri, Inc., et al.,
Plaintiffs-Respondents

On Appeal from the Supreme Court of Virginia
and on Certiorari to the United States Court
of Appeals for the Sixth Circuit and the
United States Court of Appeals for the
Eighth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF CERTAIN LAW PROFESSORS

MOTION OF CERTAIN LAW PROFESSORS FOR LEAVE TO FILE BRIEF AMICI CURIAE

The above listed 85 law professors respectfully move the Court for leave to file the accompanying brief amici curiae, in support of defendant below in Simopoulos v. Virginia (No. 81-185); plaintiffs below on all issues in City of Akron v. Akron Center for Reproductive Health, Inc. (Nos. 81-746 & 81-1172); and plaintiffs below on all issues in Planned Parenthood of Kansas City, Missouri, Inc. v. Ashcroft (Nos. 81-1255 & 81-1623), with the exception of the question of statutory construction regarding minors' consent, on which we take no position.

Amici teach in American law schools. We submit this brief to

share with the Court our support for the principles of constitutional law embodied in this Court's opinion in Roe v. Wade, 410 U.S. 113 (1973), and in the Court's subsequent applications of Roe. We believe that, as the ultimate guardian of the precious and delicate constitutional right of privacy as well as the final source of coherent constitutional doctrine, this Court must recognize the continuing validity of Roe. We, therefore, urge this Court to review with the strict judicial scrutiny used in Roe all enactments at bar regulating abortion procedures for adult women and to consider the regulations of abortions for minors against the special standard

of review articulated by this Court in recognition of the unique status of children under the law.

We have sought the consent of the parties to file a brief amici curiae. Counsel for all parties in all three cases have consented, with the exception of counsel for the Commonwealth of Virginia in Simopoulos v. Virginia (No. 81-185).

Respectfully submitted,

Professor Susan Frelich Appleton
Washington University School of Law
St. Louis, Missouri 63130
(314) 889-6449

Professor Paul Brest
Stanford Law School
Stanford, California 94305
(415) 497-3573

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BRIEF AMICI CURIAE OF CERTAIN LAW PROFESSORS

This brief is submitted by the 85 listed individual amici curiae conditionally upon the granting of the attached motion for leave to file.

INTEREST OF THE AMICI

The interest of the amici is set forth in the attached motion for leave to file.

SUMMARY OF ARGUMENT

The constitutional right of privacy, a fundamental liberty shielded by the due process clause of the Fourteenth Amendment and so recognized by this Court in Roe v. Wade, 410 U.S. 113 (1973), presumptively relegates to the individual the intensely personal choice whether or not to terminate a pregnancy. This Court has explicitly determined on many occasions that this

prima facie right encompasses freedom from direct governmental interference with the means to effectuate the abortion choice and that access to abortion is essential to the constitutionally protected right of decision.

When examining enactments regulating abortions sought by adult women, this Court has consistently used a two-step analysis: It has first decided whether the law directly interferes with or imposes any burden at all on the woman's freedom to choose abortion or to effectuate that choice. If the law does so, this Court has then applied strict judicial scrutiny, requiring the law to be not only justified by a compelling state interest but also narrowly tailored to further that

goal. In the abortion context, this Court has identified just two state interests that will reach the "compelling point" -- preserving potential life after fetal viability and protecting maternal health after approximately the end of the first trimester.

This Court's precedents as well as the precious and delicate nature of the fundamental privacy right dictate that the enactments at bar regulating access to abortions for adult women be tested within the analytical framework described above. The balancing test or the sliding scale used as a standard of review by some lower courts would threaten all fundamental constitutional rights and would continually mire the courts in circular and

standardless evaluations of the "burdensomeness" of every abortion regulation.

Because of the unique status of children under the law, this Court has required regulations of abortions sought by minors to be justified by significant state interests not present in the case of an adult, such as the interest in parental involvement. This Court's precedents have recognized, however, that to withstand constitutional attack these abortion regulations must allow mature minors to make their own decisions and must exempt from parental involvement minors whose best interests so require.

ARGUMENT

I.

The fundamental constitutional right of privacy, as elaborated by this Court in Roe v. Wade, protects a woman's abortion decision and her access to the means to effectuate that decision from the direct governmental interference imposed by the regulations now before this Court.

In Roe v. Wade, 410 U.S. 113 (1973), this Court held unconstitutional a Texas statute criminalizing all but life-saving abortions because the "right of privacy ... is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." Id. at 153. In so holding, this Court did not decide that abortion is a desirable response to an unhealthful or unwanted pregnancy; instead, it recognized simply that the "Fourteenth Amendment's concept of personal liberty and restrictions upon state

action" presumptively relegate such intensely personal and sensitive matters of conscience to individual choice, not government control. Id.; see Tribe, The Supreme Court, 1972 Term--Foreword: Toward a Model of Roles in the Due Process of Life and Law, 87 Harv. L. Rev. 1 (1973).

The prima facie constitutional right recognized in Roe belongs to the pregnant woman, Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977), although this Court has made plain the indispensable role of her physician's best medical judgment in considering all factors relating to her pregnancy, in assisting her in the decisionmaking process, and in implementing her decision, should she choose abortion. See Roe, 410 U.S. at 153, 163; Doe v. Bolton, 410 U.S.

179, 192, 196-97 (1973); Connecticut v. Menillo, 423 U.S. 9 (1975); Colautti v. Franklin, 439 U.S. 379, 387 (1979). Abortion is, after all, a medical procedure, Roe, 410 U.S. at 166, and constraints on a physician's exercise of his best medical judgment necessarily interfere with "the woman's freedom to make a constitutionally protected decision," Whalen, 429 U.S. at 605 n.33.

The zone of privacy shielded by the Fourteenth Amendment, under Roe, encompasses not only "the interest in independence in making certain kinds of important decisions," Whalen, 429 U.S. at 599-600, but also the complementary and inseparable interest in being permitted to effectuate those decisions. See Paul v. Davis, 424 U.S.

693, 713 (1976) (emphasis added) ("limitations on States' power to substantively regulate conduct" in privacy matters). In other words, the interest that Roe found constitutionally secured is not just a theoretical interest in abstract decisionmaking on the subject of abortion; rather, this Fourteenth Amendment liberty necessarily includes protection from unjustified governmental interference with the means of effectuating a woman's abortion choice. Regarding the first trimester of pregnancy, for example, this Court held in Roe that "[i]f [the abortion] decision is reached, the judgment may be effectuated by an abortion free of interference by the State," 410 U.S. at 163 (emphasis added), and that "the abortion decision and its effectuation

must be left to the medical judgment of the pregnant woman's attending physician," id. at 164 (emphasis added).

This principle was forcefully reaffirmed in Carey v. Population Services International, 431 U.S. 678 (1977), where this Court found its privacy precedents to "establish that the same test must be applied to state regulations that burden an individual's right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision as is applied to state statutes that prohibit the decision entirely." Id. at 688. This Court reasoned that "access is essential to exercise of the constitutionally protected right of decision in matters of childbearing that is the under-

lying foundation of the [holding] in ... Roe v. Wade." Id. at 688-89. Thus, New York's restrictions on access to contraceptives, including a requirement that only licensed pharmacists distribute contraceptives, were invalid because they unjustifiably burdened the right of individuals to use such items. Id. at 686-90.

This Court's repeated reliance on the reasoning used in Roe to strike down restrictions falling far short of complete prohibitions of abortions clearly demonstrates the centrality of access to the means of effectuating the abortion decision. For example, Roe's reasoning was invoked in its companion case, Doe v. Bolton, to overturn the procedural provisions of Georgia's "modern" abortion legislation, includ-

ing special hospitalization, accreditation, committee-approval, and two-doctor concurrence requirements. These requirements did not bar abortions altogether, and abortions remained available so long as physicians complied (under threat of criminal penalties) with these regulations. Nonetheless, this Court concluded that Georgia had, without sufficient justification, limited a physician's exercise of his best medical judgment--and thus derivatively his patient's right of privacy. 410 U.S. at 192-200. Three years later, Missouri's spousal consent requirement and its ban on saline amniocentesis (a then popular method of second-trimester abortion) fell when subjected to the analysis dictated by Roe and Doe. Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

Both requirements, provisions accompanied by criminal sanctions for noncompliance, blocked a woman's access without, however, completely prohibiting abortion.

The constitutional constraints that prevent government from interfering with the abortion choice and its effectuation do not require government actively to assist women to obtain abortions, even women unable to afford to pay for such treatment themselves. Harris v. McRae, 448 U.S. 297 (1980) (federal government); Williams v. Zbaraz, 448 U.S. 358 (1980) (states). Taking care to emphasize the continuing validity of the Roe doctrine, this Court has determined that government inaction--such as the failure to fund abortions for the indigent--simply does not impinge on the protected right to obtain an abortion, free from official

interference. McRae, 448 U.S. at 314, 318.[1/]

The cases at bar raise a number of questions virtually identical to issues that this Court has resolved definitively in the past. The question of abortion access--or protection from direct interference with the means of effectuating the abortion decision--is squarely presented by the requirements that all abortions after the first trimester be performed in hospitals;[2/]

1/ A well-defined line separates active or direct interference with the right recognized in Roe and governmental failure to provide abortions for all. See McRae; Maher v. Roe, 432 U.S. 464 (1977). See also Colautti v. Franklin, 439 U.S. 379, 386 n.7 (1979).

2/ All three cases now before this Court present challenges to hos-

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that the attending physician personally inform the patient of facts relating to her pregnancy, the abortion procedure, fetal characteristics, agencies available to assist her, appropriate postoperative care, and the risks of the abortion technique to be used;[3/] that the abortion patient wait

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pitalization requirements for all abortions performed after the first trimester.

3/ Plaintiffs below in Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F.Supp. 1172 (N.D. Ohio 1979), aff'd in part, rev'd in part, 651 F.2d 1198 (6th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172), challenge provisions of an Akron, Ohio city ordinance containing the requirements described in text accompanying notes 3-4.

twenty-four hours between giving her informed consent and the performance of an abortion;[4/] that a second physician attend the abortion of a viable fetus;[5/] and that pathology reports by qualified pathologists be prepared following all abortions.[6/] Like the two-doctor concurrence and hospital-accreditation requirements invalidated

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4/ See note 3 supra.

5/ Plaintiffs below in Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft, 483 F.Supp. 679 (W.D. Mo. 1980), aff'd in part, rev'd in part, 655 F.2d 848 (8th Cir.), on remand, 664 F.2d 687 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623), challenge provisions of a Missouri statute containing the requirements described in text accompanying notes 5-6.

6/ See note 5 supra.

in Doe and the spousal consent rule and saline amniocentesis ban overturned in Danforth, these restrictions do not entirely prohibit obtaining an abortion. Yet all of the limitations now before this Court, according to the records, make effectuating the abortion decision of adult women more onerous, more costly, more time-consuming, more difficult, and--sometimes--more hazardous.7/

7/ Courts have determined that mandatory waiting periods, like those imposed by the Akron ordinance, see note 4 and accompanying text supra, increase the health risks to the abortion patient by delaying the procedure as her pregnancy advances. See, e.g., Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft, 655 F.2d 848, 866 (8th Cir. 1981) (48-hour waiting period), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255

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None of these enactments could even arguably be characterized as a mere failure to provide active governmental assistance, to be reviewed according to the analysis in the abortion-funding cases. See, e.g., Harris v. McRae, 448 U.S. 297 (1980). Instead, these enactments are state-created obstacles to abortion imposed through affirmative regulation of private conduct and policed with criminal

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& 81-1623); Planned Parenthood League v. Bellotti, 641 F.2d 1006, 1014 (1st Cir. 1981) (24-hour waiting period); Charles v. Carey, 627 F.2d 772, 785 (7th Cir. 1980) (24-hour waiting period). Hospitalization requirements, see note 2 supra, may also increase the health risks of abortion. See Ashcroft, 655 F.2d at 856-57.

penalties for noncompliance. They treat abortion differently from any other medical service, overriding standard medical practice and individual professional judgment. They interfere directly with the prima facie right of privacy of adult women elaborated in Roe, and they call for review against the standard used by this Court in Roe and in all subsequent abortion cases involving direct interference with the constitutional right of privacy of adult women: strict judicial scrutiny.[8/]

8/ This Court's validation in Danforth of Missouri's written consent and recordkeeping requirements can easily be reconciled with the above con-

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clusions. The written consent requirement imposes no burden on the privacy right but simply verifies that the abortion decision is made by the individual to whom the protected privacy right belongs, the pregnant woman. The recordkeeping requirement, albeit for slightly different reasons, imposes "no legally significant impact or consequence on the abortion decision or on the physician-patient relationship." Danforth, 428 U.S. at 81. The Court's treatment of both these issues is elaborated further in part II B infra.

II.

This Court must scrutinize the abortion regulations now before it against the single standard, strict judicial scrutiny, consistently applied to all regulations directly imposing any burden on the adult woman's privacy right; a more relaxed test allowing ad hoc evaluations of the degree of the burden inflicted by abortion regulations would undermine a fundamental constitutional right, conflict with this Court's precedents, and create a judicially unmanageable standard for all fundamental-rights cases.

A.

Under Roe v. Wade, the abortion regulations now before this Court must be narrowly drawn to advance one of two possible compelling state interests: maternal health (compelling only after approximately the end of the first trimester) and potential life (compelling only after fetal viability).

This Court carefully explained that the liberty recognized in Roe v. Wade, although neither absolute nor

unqualified, is a "fundamental right." 410 U.S. at 153-55. To withstand the strict judicial scrutiny evoked by such protected interests, any governmental restriction interfering with the right of an adult woman to terminate a pregnancy "may be justified only by a 'compelling state interest'" and "must be narrowly drawn to express only the legitimate state interests at stake." Id. at 155. See Carey v. Population Services International, 431 U.S. 678, 686 (1977). The abortion regulations at bar must be tested against this standard.

In Roe and its successors, this Court identified only two state interests that become sufficiently compel-

ling at particular points in pregnancy to meet this test. First, a state's interest in protecting potential life becomes sufficiently compelling to justify abortion restrictions narrowly designed to further that goal only after viability, the point of fetal capacity for meaningful extrauterine survival. Roe, 410 U.S. at 163.[9/]

Second, the interest a state may assert in protecting maternal health matures to "the 'compelling' point" only at "approximately the end of the first trimester" of pregnancy, id. at 163, because until that time--according

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9/ See also Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 63-65 (1976); Colautti v. Franklin, 439 U.S. 379 (1979).

to the medical literature available in 1973--"mortality in abortion may be less than mortality in normal childbirth," id; see id. at 149; Connecticut v. Menillo, 423 U.S. 9, 11 (1975). Restricting abortion during the first trimester because of the purported danger of the procedure would, therefore, only subject pregnant women to the greater health hazards posed by delivery, the inevitable end of an uninterrupted pregnancy. The logic of this conclusion necessarily transcends the particular timetable developed by this Court in 1973. Thus, as abortion techniques become more sophisticated, the comparative dangers of abortion at any point in pregnancy as opposed to child-

birth will change. The post-first-trimester hospitalization requirements raised by all three cases now before this Court must be examined in this light.

After this "compelling point," the Constitution allows states to enact abortion regulations that "reasonably [relate] to the preservation and protection of maternal health." Roe, 410 U.S. at 163. The reference to "reasonableness" here not is a departure from application of the "compelling state interest" test, but instead reflects the analysis used by this Court to ascertain whether that test, with its requirement of narrowly tailored enactments, was satisfied: Abortion regu-

lations that depart from established medical practices are insupportable on health grounds because they unnecessarily constrain the physician's exercise of his best medical judgment, recognized by this Court as the strongest safeguard of maternal health. See Doe v. Bolton, 410 U.S. 179, 192, 195, 197 (1973). They may therefore increase the risks of abortion without conferring any health benefits in return. They may also force women to undergo the often greater health risks of childbirth by limiting the availability of abortions. See Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 77-78 (1976). Such unnecessary abortion restrictions are,

as a result, unreasonable on health grounds and thus are not narrowly drafted to advance a compelling state interest in protecting maternal health.

Because neither the interest in preserving potential life nor the interest in protecting maternal health is compelling during the first trimester of pregnancy, throughout that stage "the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated." Roe, 410 U.S. at 163. This Court has rejected the argument that a state has any sufficiently compelling interests to limit an adult woman's

liberty to effectuate the abortion decision during the first trimester. See id. at 162-64.

B.

This Court's precedents dictate a two-step inquiry to ascertain whether the abortion regulations at bar are unconstitutional: do the regulations impose any burden at all on the abortion decision and its effectuation and, because these regulations directly impose such burdens, do they fail to satisfy the "compelling state interest" test?

In cases involving governmental interference with an adult woman's abortion decision or with her access to the means to effectuate that decision, this Court has never wavered from applying the "compelling state interest" test employed in Roe. See Carey v. Population Services International, 431 U.S. 678, 688 (1977) (same "compel-

ling state interest" test must be applied to restrictions on abortion access as to complete prohibitions). For example, Georgia's special hospitalization and accreditation regulations, unable to withstand this Court's strict judicial scrutiny because they applied indiscriminately even to the first trimester, fell in Doe v. Bolton, 410 U.S. 179, 194-95 (1973). Similarly, a number of Missouri abortion restrictions, including a spousal consent requirement and a ban on saline amniocentesis, were declared unconstitutional because they failed to prove necessary to advance either of the two compelling state interests identified in Roe. Planned Parenthood of Central Missouri

v. Danforth, 428 U.S. 52, 69 (1976) (spousal consent law impermissibly covers even first trimester); id. at 79 (saline amniocentesis ban "fails as a reasonable regulation for the protection of maternal health").

This Court has applied a less stringent test to abortion laws only where the state has not acted affirmatively at all to impinge on a woman's right to obtain an abortion or where a regulation does not interfere--even to a minimal extent--with that right. Thus, for example, this Court has not applied the "compelling state interest" test to governmental failure to fund abortions for the indigent, inaction imposing "no restriction on access to

abortions that was not already there." Maher v. Roe, 432 U.S. 464, 474 (1977); see Harris v. McRae, 448 U.S. 297 (1980). Similarly, simple written-consent and recordkeeping requirements have not evoked this Court's strictest scrutiny because these regulations in no way interfere with a woman's ability to decide to obtain an abortion and to effectuate that decision. A simple[10/] written-consent requirement merely assures that the abortion deci-

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10/ The Court cautioned in Danforth that elaborate or detailed informed-consent requirements "might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession," thus infringing the patient's right of privacy. 428 U.S. at 67 n.8.

sion has been made by the pregnant woman herself, the individual to whom the constitutional right of privacy belongs, see note 8 supra, while mandated recordkeeping of the sort considered in Danforth has "no legally significant impact or consequence on the abortion decision or on the physician-patient relationship," Danforth, 428 U.S. at 81 (emphasis added). See Whalen v. Roe, 429 U.S. 589, 607 (1977) (Brennan, J., concurring) (absent a deprivation of constitutionally protected liberty, state need not show law necessary to compelling state interest).

This Court's precedents thus unequivocally dictate a two-step inquiry for ascertaining the constitutionality

of a challenged abortion regulation. First, a court must examine whether or not the regulation is state action imposing any burden at all on the right to obtain an abortion. The question here is not one of degree but simply whether the regulation affirmatively imposes any legally cognizable burden. If it does not, then the analytical framework developed in Roe does not govern. See Danforth; Maher; McRae. If, however, the regulation imposes any burden on the right recognized in Roe, then, as a second step, strict judicial scrutiny must be applied to determine whether that burden is undue--that is, whether it is properly justified by

a compelling state interest and sufficiently narrowly tailored to further that goal. See McRae, 448 U.S. at 314; Maher, 432 U.S. at 473-74.

Roe made plain the principles controlling during this second step of the inquiry: the lack of any compelling state interest during the first trimester of pregnancy, the compelling character of a state's interest in protecting maternal health only after the first trimester,[11/] and the compelling character of a state's interest in preserving potential life only after fetal viability. 410 U.S. at 163-64.

As noted earlier, all of the regu-

11/ But see pages 23-24 supra.

lations now before this Court interfere directly with the right recognized in Roe; according to the records, they significantly burden the abortion decision and its effectuation by making termination of a pregnancy more onerous, more costly, more time-consuming, more difficult, and--sometimes-- more hazardous.12/

Under the strict judicial scrutiny that must therefore govern, all of the measures applicable to abortions sought by adult women during the first trimester must fall because neither state interest identified in Roe is sufficiently compelling during that stage

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12/ See note 7 supra.

to support such restrictions. All of the first-trimester regulations challenged here are, consequently, "unduly burdensome." See McRae, 448 U.S. at 314, Maher, 432 U.S. at 473-74 (Roe doctrine "protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy"). These impermissible first-trimester regulations include the requirements that the attending physician personally inform the patient of facts relating to her pregnancy, the abortion procedure, fetal characteristics, agencies available to assist her, appropriate postoperative care, and the risks of the abortion technique

to be used;[13/] that the abortion patient wait twenty-four hours between the giving of her informed consent and the performance of an abortion;[14/] and that pathology reports by qualified pathologists be prepared after all abortions.[15/]

The measures before this Court regulating abortions after the first trimester must also be tested against the Roe standard. This Court must determine whether Missouri, Virginia and Akron, Ohio have established that

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13/ See note 3 supra.

14/ See notes 3-4 supra.

15/ See notes 5-6 supra.

their hospitalization requirements for all abortions performed after the first trimester are necessary to protect maternal health and that those requirements are drafted narrowly to achieve that legitimate goal.16/ Current medical knowledge regarding the relative safety of various abortion techniques and the comparative risks of childbirth

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16/ See note 2 supra. Because the constitutional right at stake is fundamental, the state (or city) bears the burden of satisfying the "compelling state interest" test. See, e.g., Roe, 410 U.S. at 155. See also Moore v. City of East Cleveland, 431 U.S. 494, 499 (1977) (plurality opinion). The court in Simopoulos v. Commonwealth, 277 S.E.2d 194, 204 (Va. 1981), probable jurisdiction noted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (No. 81-185), thus incorrectly presumed the constitutionality of Virginia's mandatory hospitalization law.

and abortion must figure in this analysis, as it has in this Court's precedents. See Roe, 410 U.S. at 163; Danforth, 428 U.S. at 76-79; part II A supra. For example, the finding by the district court in Ashcroft, affirmed by the court of appeals, regarding the comparable safety of D & E procedures inside and outside hospitals must be a determinative consideration. Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, 664 F.2d 687, 690 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623).

Similarly, Missouri's law mandating the attendance of a second physi-

cian at the abortion of a viable fetus[17/] will survive the required strict scrutiny only if determined to be narrowly tailored to advance the state's interest in preserving potential life after the relevant "compelling point," fetal viability. See Colautti v. Franklin, 439 U.S. 379 (1979). The district court, affirmed by the court of appeals, found this law unconstitutionally overbroad because it covered even those abortions which maternal health considerations required to be performed by means incompatible with

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17/ See note 5 supra.

fetal survival.[18/] Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, 655 F.2d 848, 865-66 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623).

In sum, Roe and its successors dictate the controlling standard of review, strict scrutiny, that must apply to the regulations challenged here as well as the identity and scope of the two state interests that may be sufficiently compelling to support narrowly drawn abortion limitations.

18/ Under Roe, even though a state may generally go so far as to proscribe post-viability abortions, it cannot do so in cases where maternal life or health would be jeopardized. 410 U.S. at 164, 165.

C.

Only the "compelling state interest" test--applied here and in all fundamental-rights cases--promises adequate protection of fundamental constitutional rights, consistency with this Court's precedents, and elimination of the uncertainty that a variable standard of review resting on ad hoc assessment of burdens generates.

The reasons are plain why this Court will continue to adhere to the two-step inquiry dictated by its precedents, instead of resorting to a balancing test[19/] or sliding

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19/ Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172, 1200 (N.D. Ohio 1979) (defining balancing test). See id. at 1207 (applying balancing test).

The district court in the Akron case (Nos. 81-746 & 81-1172) used a balancing test on the theory that only

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scale[20/] based upon ad hoc evaluations

Footnote continued

an absolute prohibition or veto of the abortion decision must be justified by a compelling state interest and narrowly drawn to further that goal. "Lesser" invasions of the privacy right require a court simply to weigh the "degree" of interference against "any valid state interest furthered by such" regulation. Id. at 1200.

The district court's erroneous conclusion about the appropriate standard of review stems from its effort to read this Court's treatment of direct interference with an adult woman's right of privacy together with the opinions in two very different areas: cases concerning the privacy rights of minors, where this Court has applied a distinct standard of review, see part III infra, and the abortion-funding cases, where the lack of any active governmental interference with the abortion decision eliminates the need for strict scrutiny, see, e.g., Harris v. McRae, 448 U.S. 297 (1980).

20/ Judge Kennedy, concurring in part and dissenting in part in the Akron

(Footnote continued on following page)

of the degree of the burden arguably imposed by each and every abortion regulation.

Footnote continued

case (Nos. 81-746 & 81-1172), fashioned a sliding scale under which the intensity of the judicial scrutiny is determined by the degree of the burden an abortion regulation imposes. Unlike the district court, see note 19 supra, Judge Kennedy would not confine strict scrutiny to absolute prohibitions and vetoes of the abortion decision. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1215 (6th Cir. 1981) (Kennedy, J., concurring and dissenting). Unlike the majority of the court of appeals, however, Judge Kennedy would eschew the two-step inquiry and would decline to apply strict scrutiny to all restrictions imposing any burden on the abortion decision. Id. n.5.

The basic flaw in Judge Kennedy's analysis is the same as that in the district court opinion: an attempt to unify several clearly and explicitly distinguished lines of cases. See note 19 supra.

First, as this Court emphasized decades ago, "it is the character of the right, not of the limitation, which determines what [constitutional] standard governs the [legislative] choice." Thomas v. Collins, 323 U.S. 516, 530 (1945). That principle remains sound law today. See Schad v. Borough of Mount Ephraim, 452 U.S. 61, 68 (1981). Constitutional rights properly deemed fundamental, such as the right to decide to terminate a pregnancy and the right to effectuate that decision, require the vigorous protection from governmental intrusions that only strict judicial scrutiny, applied to every direct interference or burden, affords.

The right of privacy, in particular, which limits the government's power to intervene in intensely personal decisions and their effectuation, demands the most stringent standard of judicial review. A matter as sensitive as whether or not to terminate a pregnancy--fraught as it is with intractable questions about the beginning of human life--simply cannot be left to majoritarian resolution, under which any number of impediments to abortion might be reasonable if predicated upon one of several competing and ultimately unverifiable theories of human existence. This Court has thus recognized that the Fourteenth Amendment's due process clause prima facie guarantees

to the individual the power to resolve such questions. Roe v. Wade, 410 U.S. at 162 (Texas may not override the rights of the pregnant woman by adopting one theory of life); Bellotti v. Baird, 443 U.S. 622, 655 (1979) (Stevens, J., concurring) ("It is inherent in the right to make the abortion decision that the right may be exercised without public scrutiny and in defiance of the contrary opinion of the sovereign...."); Tribe, The Supreme Court, 1972 Term--Foreword: Toward a Model of Roles in the Due Process of Life and Law, 87 Harv. L. Rev. 1 (1973).

This Court has carefully crafted the "compelling state interest" test

so that truly overriding governmental concerns, if advanced by narrowly drafted laws, can impinge on fundamental liberties, including the right of privacy. Under such circumstances, a deprivation of liberty is constitutionally justified, and the ultimate judgment will be that that deprivation is not "unduly burdensome." See generally Note, Of Interests, Fundamental and Compelling: The Emerging Constitutional Balance, 57 B.U.L. Rev. 462 (1977). To suggest, as some lower courts have, that strict scrutiny controls only when the burden on the privacy right is thought, in the first

instance, to be "undue"[21/] is to turn this Court's preservation of individual constitutional rights on its head. Lowering the standard of review for

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21/ See, e.g., Leigh v. Olsen, 497 F.Supp. 1340, 1343, 1346 (D.N.D. 1980) (regulations not unduly burdening abortion decision need be only rational; statute requiring patient to be informed of alternatives to abortion bears reasonable relation to informed consent and state's preference for childbirth). But see Charles v. Carey, 627 F.2d 772, 777 (7th Cir. 1980): "[T]he term 'undue burden' defines the ultimate constitutional issue, not merely the threshold requirement for strict scrutiny." Other courts have adopted this well-reasoned statement of the law. E.g., Planned Parenthood Ass'n of Kansas City, Inc. v. Ashcroft, 655 F.2d 848, 855 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623); Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1204 (6th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172).

arguably "lesser" infringements would eviscerate the protection of fundamental rights by sustaining such infringements even if overbroad or unrelated to a compelling interest.22/

Moreover, because the operative element in such analysis would be the perceived degree of the burden imposed,

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22/ For example, the district court in the Akron case sustained several first-trimester abortion regulations (including a detailed "informed-consent" requirement and a mandatory twenty-four-hour waiting period) because they furthered "valid state interests in maternal health and welfare" without cumulatively making abortion "so much more expensive" as to effect a veto of a woman's decision. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172, 1207 (N.D. Ohio 1979), aff'd in part, rev 'd in part, 651 F.2d 1198 (6th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172).

no unique feature of abortion litigation would confine this variable standard of review to those cases alone; all fundamental rights would be equally susceptible of such diluted protection. See Appleton, Beyond the Limits of Reproductive Choice: The Contributions of the Abortion-Funding Cases to Fundamental-Rights Analysis and to the Welfare-Rights Thesis, 81 Colum. L. Rev. 721, 752-53 (1981).

Apart from the precious and delicate nature of the privacy right and the resulting need for heightened judicial protection, the analytical framework that this Court has consistently followed since Roe must be retained because it is the only one capable of

coherent judicial administration. Use of a balancing test[23/] or a sliding scale[24/] in order to set a standard of review is entirely unworkable for two reasons.

First, it is circular. It purports to prescribe a standard of review that will guide the consideration of various factors but in truth it brings all those factors into play in setting the standard.[25/] Such circularity is obviously untenable and could only raise questions about the foundation and consistency of the decisions rest-

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23/ See note 19 supra.

24/ See note 20 supra.

25/ See note 21 supra.

ing on such reasoning. In contrast, the Roe analysis is entirely straightforward. And whatever may be said about the outcome-determinative quality of strict judicial scrutiny in other contexts,[26/] this Court's identification in Roe of two state interests that eventually do become compelling demonstrates that strict scrutiny in abortion cases does not "merely [announce] an inevitable result"[27/]--unconstitution-

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26/ See Gunther, The Supreme Court, 1971 Term--Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for Newer Equal Protection, 86 Harv. L. Rev. 1, 8 (1972).

27/ Widmar v. Vincent, 102 S.Ct. 269, 279 n.3 (1981) (Stevens, J., concurring); Illinois State Bd. of Elections v. Socialist Workers Party, 440 U.S. 173, 188-89 (1979) (Blackmun, J., concurring).

ality--but instead signals an adjustment between protected rights and truly overriding governmental concerns.

Beyond its circularity, a balancing test or sliding scale is ultimately standardless. How are the degrees of interference or burden to be determined? Under a balancing test, how much additional cost[28/] must be imposed or how great must be the additional health risks before the burden of an abortion regulation outweighs, for example, a pre-viability state interest in protecting potential life? Or is "burdensomeness" measured by the number of abortions the regulation actually curtails? Under the sliding scale, how much additional cost, how great the

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28/ See note 22 supra.

health risks, or how many foregone abortions would be necessary before strict scrutiny would govern?

Instead of according more deference to state and local governments, such weaker standards of review--with their intrinsic indeterminacies--would only multiply the number of federal-state clashes, as federal courts at all levels struggled to implement that regime. The various lower courts would undoubtedly reach conflicting conclusions about the "burdensomeness" of all manner of regulations, thereby increasing the uncertainty in fundamental-rights cases generally and, in particular, compelling this Court's continuing role as the arbiter of the permissibility of every state's and every city's abortion laws.

III.

Because of the unique status of children under the law, this Court has used a special standard of review for regulations of abortions for minors, requiring states to allow mature minors to make their own abortion decisions and to free from parental involvement all those minors whose best interests so demand.

Children have occupied a unique status throughout this Court's constitutional adjudication. As a plurality of this Court observed in Bellotti v. Baird, 443 U.S. 622 (1979): "Children have a very special place in life which law should reflect. Legal theories and their phrasing in other cases readily lead to fallacious reasoning if uncritically transferred to determination of a State's duty towards children." Id. at 633-34 (plurality opinion)

(quoting May v. Anderson, 345 U.S. 528, 536 (1953) (Frankfurter, J., concurring)). Hence, "constitutional principles [must] be applied with sensitivity and flexibility to the special needs of parents and children." Bellotti, 443 U.S. at 634 (plurality opinion).

Certainly, the Constitution protects minors as well as adults. See, e.g., In re Gault, 387 U.S. 1, 13 (1967). Moreover, as this Court has recognized, adolescent pregnancy is a widespread and personally devastating occurrence.[29/] Yet because of the

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29/ See Michael M. v. Superior Court, 450 U.S. 464, 470-71 (1981) (plurality opinion); id. at 479

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unique status of children under the law, this Court has applied a special standard of review in cases examining the privacy rights of minors: "whether there is any significant state interest [supporting the regulation] that is not present in the case of an adult." Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 75 (1976); Carey v. Population Services International, 431 U.S. 678, 693 (1977) (plurality opinion). As a plurality of this Court explained in Carey, 431 U.S. at 693 n.15:

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(Stewart, J., concurring); id. at 481-82 (Blackmun, J., concurring); Carey v. Population Servs. Internat'l, 431 U.S. 678, 696 & n.21 (1977) (plurality opinion).

> This test is apparently less rigorous than the "compelling state interest" test applied to restrictions on the privacy rights of adults. Such lesser scrutiny is appropriate both because of the States' greater latitude to regulate the conduct of children, Prince v. Massachusetts, 321 U.S. 158 (1944); Ginsberg v. New York, 390 U.S. 629 (1968), and because the right of privacy implicated here is "the interest in independence in making certain kinds of important decisions," Whalen v. Roe, 429 U.S. 589, 599-600 (1977), and the law has generally regarded minors as having a lesser capability for making important decisions. See, e.g., Planned Parenthood, 428 U.S., at 102 (Stevens, J., concurring in part and dissenting in part).

This Court's repeated emphasis of the long held and deeply rooted doctrine according minors a unique status under the law, see Bellotti; Danforth, 428 U.S. at 74-75; Ginsberg v. New York, 390 U.S. 629, 638-41 (1968); Prince v. Massachusetts, 321 U.S. 158,

170 (1944), explicitly refutes any theory, such as that embraced by Judge Kennedy, writing separately in the Akron case, that all of this Court's privacy precedents -- those concerning minors as well as adults -- should be read together as the source of a universal, sliding-scale standard of review for abortion regulations, whether applicable to minors or adults. See Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1211-15 (6th Cir. 1981) (Kennedy, J., concurring and dissenting), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172). See also Akron Center for Reproductive Health v. City of Akron, 479 F. Supp. 1172, 1198-1200 (N.D. Ohio 1979). This

Court's precedents plainly recognize that minors' abortion rights pose problems distinct from those affecting adults and demand a distinct standard of review.

This Court has identified three concerns uniquely relevant to minors: "the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing." Bellotti, 443 U.S. at 634 (plurality opinion). Although these special concerns will not support a state-granted parental veto over a minor's abortion decision, Danforth, 428 U.S. at 74-75, a majority of the Justices of this Court would approve a more narrowly drafted statute allowing minors judicially determined to be mature to make their own

abortion decisions while requiring immature minors to obtain a consent-substitute, parental permission or judicial authorization predicated upon a determination of the minor's best interests. See Bellotti, 443 U.S. at 643-44 (plurality opinion for four Justices); id. at 656-57 (White, J., dissenting) (expressing approval of even absolute parental consent requirement).

Similarly, this Court has validated a parental notification requirement because it served not only "the important considerations of family integrity and protecting adolescents" but also "a significant state interest by providing an opportunity for parents to supply essential medical and other information to a physician." H.L. v. Matheson, 450 U.S. 398, 411 (1981). This Court did not, however, extend

that holding to mature or emancipated minors or to immature minors showing such notification detrimental to their best interests. 450 U.S. at 407 & n.14.

The abortion regulations at bar pertinent to minors must be tested against the special standard of review and in light of the special concerns for minors and their parents articulated by this Court in the past. Under these guidelines, the district court and the court of appeals correctly held unconstitutional Akron's requirement of parental or judicial consent for abortions for all minors under the age of fifteen. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172, 1201 (N.D. Ohio 1979), aff'd in part, rev'd in part, 651 F.2d 1198, 1205 (6th Cir. 1981),

cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172). This provision--enacted before this Court's decision in Bellotti--impermissibly allows parents or, alternatively, a court to veto the abortion choice of even a minor under the age of fifteen years who is sufficiently mature to reach that decision herself. See Bellotti, 443 U.S. at 643-44 (plurality opinion). Moreover, it contains no procedural safeguards that ensure an abortion for an immature minor under the age of fifteen years whose best interests require termination of her pregnancy without any parental involvement.[30/] See id. at 651. See also

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30/ Where, as here, the class addressed consists of pregnant minors below the age of fifteen, the procedures

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H.L., 450 U.S. at 413-20 (Powell, J., concurring, joined by Stewart, J.) (some minors' best interests require exemption from parental notification); id. at 446, 452-53 (Marshall, J., dissenting, joined by Brennan and Blackmun, JJ.) (same).

Without such exceptions and safeguards, this provision of the Akron ordinance fails as unconstitutionally overbroad.

CONCLUSION

For all of the reasons stated, the 85 amici respectfully submit that the prima facie privacy right recognized

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purportedly offering a meaningful alternative to parental involvement must be clearly described and easily understood. This provision of the Akron ordinance, referring only to "a court having jurisdiction," fails this test. See 479 F. Supp. at 1201.

in Roe v. Wade includes freedom to effectuate the abortion choice without government interference; that the strict judicial scrutiny used in Roe and its progeny must apply to all enactments at bar regulating abortion procedures for adult women; and that the special standard of review articulated by this Court in recognition of the unique status of children under the law must apply to the enactments at bar regulating abortion procedures for minors.

Respectfully submitted,

Professor Susan Frelich Appleton
Washington University
School of Law
St. Louis, Missouri 63130

Professor Paul Brest
Stanford Law School
Stanford, California 94305

Amicus Brief

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ON FILED
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Nos. 81-185, 81-746 and 81-1172, 81-1255 and 81-1623

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND ANNEXED BRIEF OF THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, THE NATIONAL BAR ASSOCIATION (WOMEN LAWYERS DIVISION), THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, THE NATIONAL LAWYERS GUILD, THE NATIONAL WOMEN'S HEALTH NETWORK, AND THE REPRODUCTIVE RIGHTS NATIONAL NETWORK

NADINE TAUB
15 Washington St.
Newark, New Jersey
(201) 648-5634

SYLVIA A. LAW
40 Washington Sq. So.
New York, N.Y. 10012
(212) 598-7642

ELLEN J. WINNER
Rabinowitz, Boudin, Standard,
Krinsky and Leiberman
30 East 42nd Street
New York, N.Y. 10012

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,

—v.—

CITY OF AKRON, et al.,
Defendants-Respondents.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Petitioners,

—v.—

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Petitioners,

—v.—

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Respondents.

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OTHER AUTHORITIES:

The American Promise: Equal Justice and Economic Opportunity, the Final Report of the National Advisory Council on Economic Opportunity (1981) 33

J. Bartlett, Familiar Quotations, pp. 118, 400, 407 (14th Ed. 1968) 37

Blumrosen, "Wage Discrimination, Job Segregation and Women Workers," 6 Women's Rts. L. Rep. 19 (1979-80) 11

G. Bourne and D. Danforth, Pregnancy (rev. ed. 1975) 17

Curran and Shapiro, Law, Medicine and Forensic Science, ch. 5 and 6 (1982) 42

R. Hatcher, Contraceptive Technology, 1982-1983 (11th Rev. ed. 1982) 19

S. Henshaw, et. al., "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5 (1982) — 31, 41, 44

K. Karst, "Forward: Equal Citizenship Under the Fourteenth Amendment," 91 Harv. L. Rev. 1 (1978) — 24

Oldham, "Sex Discrimination and State Labor Laws," 44 Den. L.J. 344 (1967) — 11

W. Prosser, The Law of Torts §56 (4th ed. 1971) 340-341 — 18

Regan, "Rewriting Roe v. Wade," 77 Mich L. Rev. 1569 (1979) — 17, 18

Ross, Sex Discrimination and "Protective" Labor Legislation, reprinted in Hearings on S.J. Res. 61 Before the Subcomm. on Const. Amendments of the Senate Comm. on the Judiciary, 91st Cong., 2nd Sess. 392 (1970) — 11

L. Shusterman, "Predicting the Psychological Consequences of Abortion," 13A Soc. Sci & Med. 683 (1979) — 31

L. Tribe, American Constitutional Law, p. 924 (1978) — 24

U.S. Comm'n on Civil Rights, Social Indicators of Equality for Minorities and Women (1978) 11

U.S. Dept. of Labor, 1975 Handbook on Women Workers (1975) 11

Women's Bureau, U.S. Dep't. of Labor, Summary of State Labor Laws for Women (1969), reprinted in Hearings on S.J. Res. 61 Before the Subcomm. on Const. Amendments of the Senate Comm. on the Judiciary, 91st Cong., 2nd Sess. 729 (1970) 11

Nos. 81-185, 81-746 and 81-1172,
81-1255 and 81-1623

In the
Supreme Court of the United States
October Term, 1982

Chris Simopoulos, M.D., FACOG,
Defendant-Appellant
v.
Commonwealth of Virginia,
State-Appellee

City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive Health,
Inc., et. al.,
Plaintiffs-Respondents

Akron Center for Reproductive Health,
Inc., et al.,
Plaintiffs-Petitioners
v.
City of Akron, et al.,
Defendants-Respondents

Planned Parenthood Association of
Kansas City, Missouri, Inc., et. al.,
Plaintiffs-Petitioners
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents

John L. Ashcroft, Attorney General of the State of Missouri, et al.,
Defendants-Petitioners
v.
Planned Parenthood Association of Kansas City, Missouri, Inc., et al.,
Plaintiffs-Respondents

On Appeal from the Supreme Court of Virginia and on Certiorari to the United States Court of Appeals for the Sixth Circuit and the United States Court of Appeals for the Eighth Circuit

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MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, THE NATIONAL BAR ASSOCIATION (WOMEN LAWYERS DIVISION), THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, THE NATIONAL LAWYERS GUILD, THE NATIONAL WOMEN'S HEALTH NETWORK, AND THE REPRODUCTIVE RIGHTS NATIONAL NETWORK

The undersigned, as counsel for the Committee for Abortion Rights and Against Sterilization Abuse (CARASA), The National Bar Association (Women Lawyers Division), The National Emergency Civil Liberties Committee (ECLC), The National Lawyers Guild, The National Women's Health Network, and The Reproductive Rights National Network, respectfully move this Court for leave to file the accompanying brief amici curiae.

Amici organizations have all been actively involved in representing the interests of women adversely affected by legal restrictions on access to safe abortion services. Amici organizations support rights of reproductive freedom, including the rights to choose parenthood, to obtain abortions

and to be free from involuntary and coerced sterilization. Amici are particularly concerned that state action making abortion services expensive and inaccessible have a disporportionately harsh burden on poor, working and minority women.

THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE (CARASA) was formed in 1977 in response to the reaction against gains that women achieved in relation to sex based equality and reproductive freedom. It was founded by concerned women, who feared that poor women's limited access to abortion and the easy availability of sterilization would increase the incidence of sterilization abuse.

CARASA has several hundred active members working in the community to educate and organize people, and in the legislature to assure access to abortion, freedom from involuntary sterilization and a decent quality of life in which people can raise their children.

THE NATIONAL BAR ASSOCIATION, WOMEN LAWYERS DIVISION, founded in 1925, is a professional membership organization which represents more than 13,000 Black attorneys, judges and law students. Its purposes include achieving equal opportunities for minorities in the legal profession and protecting the civil and political rights of all citizens. To effectuate its goal of racial and sexual equality,

the National Bar Association, through its Women's Division, has been actively involved in issues concerning child abuse and reproductive freedom.

THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE ("ECLC") is a not-for-profit organization dedicated to the defense of the Bill of Rights and its extension to all our people -- particularly the poor and the powerless. Founded in 1951, the organization has worked to achieve these goals through litigation and public education. Among the cases it has sponsored in this Court are Kent v. Dulles, 357 U.S. 116, Kleindienst v. Mandel, 408 U.S. 753, and Law Students Civil Rights Research Council, Inc. v. Wadmond,

401 U.S. 154. Through similar means, it has sought to protect the right of reproductive freedom and the right to equal protection of the law at issue in this case.

THE NATIONAL LAWYERS GUILD ("NLG") is an organization of 7,000 lawyers, law students and legal workers dedicated to the goal of full equality for all people. Since its inception in 1937, the NLG has worked consistently for the advancement of the rights of poor and working people, racial minorities and women.

In the past decade, its work to support the women's movement has become an organizational priority. The National Lawyers Guild, a founding member of the Reproductive Rights

National Network, is actively involved in protection of reproductive rights for poor, minority and working women. Individual NLG members, in cases brought throughout the nation, represent litigants seeking to prevent cutbacks in abortion funding or attempting to end sterilization abuse.

THE NATIONAL WOMEN'S HEALTH NETWORK is a national consumer organization which focuses on women's health. It has 10,000 individual members and, in addition, 300 organizational members including health centers, consumer groups and women's health organizations. It is the only national consumer organization focusing on a broad range of women's health issues.

THE REPRODUCTIVE RIGHTS NATIONAL NETWORK is a national organization working to defend abortion rights, end sterilization abuse, reduce infant mortality, assure adequate childcare services, and promote lesbian rights. More than 80 organizations participate in the NETWORK, doing activist work on reproductive health issues from a feminist prospective.

The annexed brief argues that Commonwealth of Virginia, the City of Akron, and the State of Missouri violate the constitutional rights of women by placing onerous and wholly unjustified restrictions on access to abortion. Because these restrictive laws are premised upon and perpetuate inaccurate stereotypes about the

incompetence of women, the constitutional guarantee of sex based equality, as well as the constitutional right to privacy recognized in Roe v. Wade, compell invalidation of the challenged provisions.

We have sought the consent of the parties to file this brief amici curiae. Counsel for all parties in all three cases have consented, with the exception of counsel for the Commonwealth of Virginia in Simopoulos v. Virginia (No. 81-185).

Respectfully submitted,

Sylvia A. Law

Sylvia A. Law
40 Washington Sq. So.
New York, N.Y. 10012

Nadine Taub
15 Washington St.
Newark, N.J.

Ellen J. Wirmer
Rabinowitz, Boudin, Standard,
Krinsky and Leiberman
30 East 42nd Street
New York, N.Y. 10012

Nos. 81-185, 81-746 and 81-1172,
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Defendant-Appellant
v.
Commonwealth of Virginia,
State-Appellee

City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive Health,
Inc., et. al.,
Plaintiffs-Respondents

Akron Center for Reproductive Health,
Inc., et al.,
Plaintiffs-Petitioners
v.
City of Akron, et al.,
Defendants-Respondents

Planned Parenthood Association of
Kansas City, Missouri, Inc., et. al.,
Plaintiffs-Petitioners
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents

John L. Ashcroft, Attorney General of
the State of Missouri, et al.,
Defendants-Petitioners
v.
Planned Parenthood Association of
Kansas City, Missouri, Inc., et al.,
Plaintiffs-Respondents

On Appeal from the Supreme Court of Virginia
and on Certiorari to the United States Court
of Appeals for the Sixth Circuit and the
United States Court of Appeals for the
Eighth Circuit

BRIEF AMICI CURIAE OF THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, THE NATIONAL BAR ASSOCIATION (WOMEN LAWYERS DIVISION), THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, THE NATIONAL LAWYERS GUILD, THE NATIONAL WOMEN'S HEALTH NETWORK, AND THE REPRODUCTIVE RIGHTS NATIONAL NETWORK

This brief is submitted by the undersigned amici curiae conditionally upon the granting of the motion for leave to file to which it is attached.

INTEREST OF AMICI

The interest of the amici is set forth in the attached motion for leave to file.

SUMMARY OF ARGUMENT

Until quite recently, the law sharply restricted the opportunities of women in wage work and public life. A central justification for such laws was to protect and maintain women in their biologically ordained role as mothers. Since 1971 this Court has repeatedly affirmed that gender based laws "must carry the burden of showing an 'exceedingly persuasive justifica-

tion'. . ." Miss. Univ. for Women v. Hogan, 50 U.S.L.W. 5068, 5070 (1982).

State action restricting access to abortion imposes onerous costs upon women. In the guise of protecting women, such laws compel an enormous sacrifice of women's physical integrity and personal autonomy.

The laws challenged in these cases require that physicians abandon standard medical practice and considered professional judgment; criminal penalties enforce compliance. In the many areas where hospitals are inaccessible to physicians providing abortions, the effect of the "protective" hospitalization requirement is to force the woman to endure an unwanted pregnancy. Similarly, the mandatory "informed"

consent and waiting period requirements exact high costs from women and physicians, solely to perpetuate the inaccurate stereotype of the woman as incapable of moral and practical decisionmaking, and to force her to accept her maternal destiny.

ARGUMENT

I. Historically Differences in Reproductive Capacity of Men and Women Have Provided A Primary Justification for Laws Creating a Separate, Inferior Status for Women.

Since 1971 this Court has repeatedly recognized that "legislative classifications which distribute benefits and burdens on the basis of gender carry the inherent risk of reinforcing the stereotypes about the 'proper place' of women and their need

for special protection." Orr v. Orr, 440 U.S. 268, 283 (1979). Laws premised on stereotypes about men and women are destructive, and constitutionally infirm, not only because they hurt individual men and women who do not fit the stereotype, but also because they are self-fullfilling. As the Court stated, in striking down the Utah law requiring that parents support their male children until age 21 and their female children only until age 18:

> No longer is the female destined solely for the home and the rearing of the family, and only the male for the marketplace and the world of ideas. . .If the female is not to be supported so long as the male, she hardly can be expected to attend school as long as he does, and bringing her education to an end earlier coincides with the role-typing

> society has long imposed. Stanton v. Stanton, 421 U.S. 7, 14-15 (1975).

Only last term, this Court eloquently reaffirmed that "the party seeking to uphold a statute that classifies individuals on the basis of their gender must carry the burden of showing an 'exceedingly persuasive justification' for the classification." Miss. Univ. for Women v. Hogan, 50 U.S.L.W. 5068, 5070 (1982).

The Court and the country have not always been sensitive to the oppression of sex based discrimination. "There can be no doubt that our Nation has had a long and unfortunate history of sex discrimination." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). There is also no doubt

that this unfortunate history of sex discrimination was primarily justified by the differences in reproductive capacity of men and women. The biological fact that women are capable of bearing children has been used to legitimate legislation creating a separate system of rights and responsibilities for women, and judicial approval of laws to "protect" and maintain women in their biologically ordained role as mothers.

This Court's approval of separate spheres for men and women based on women's reproductive capacity was first set forth in Bradwell v. Illinois, 83 U.S. (16 Wall) 130 (1873). Myra Bradwell had met all the qualifications to become a member of

the Illinois bar except for one - she was not a male. The Court faced the question whether a state could deny her the occupation of her choice solely because she was female and answered that it could. Justice Bradley's concurrance is the classic statement of the 19th century view of women's place in this society:

> ...the civil law, as well as nature herself, has always recognized a wide difference in the respective spheres and destinies of man and woman. Man is, or should be, woman's protector and defender. The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life. The constitution of the family organization, which is founded in the divine ordinance as well as in the nature of things, indicates the domestic sphere as that which properly belongs to the domain and functions of womanhood ...

> The paramount destiny and mission of woman are to fulfill the noble and benign offices of wife and mother. This is the law of the creator. And the rules of civil society must be adopted to the general constitution of things ... Bradwell v. Illinois 83 U.S. (16 Wall) at 141.

This "noble and benign" mission of motherhood denied Myra Bradwell the right to practice law; Justice Bradley perceived it was "the law of the creator," not the state, which constructed this dual system of rights.

Bradwell was only the beginning of this Court's endorsement of discrimination against working women in the guise of protection. In Muller v. Oregon, 208 U.S. 412 (1908), this Court again viewed women's anatomy as destiny.

> That women's physical structure and the performance of maternal functions place her at a disadvantage in the struggle for subsistence is obvious. This is especially true when the burdens of motherhood are upon her. Even when they are not, by abundant testimony of the medical fraternity continuance for a long time on her feet at work, repeating this from day to day, tends to injurious effect upon the body, and as healthy mothers are essential to vigorous offspring, the physical well-being of women becomes an object of public interest and care in order to preserve the strength and vigor of the race. Muller, 208 U.S. at 421.

The need for a woman to "proper[ly] discharge her maternal function" justified the maximum hours law in Muller, 208 U.S. at 422, and other laws "protecting" women by limiting

their employment opportunities.[1/] These laws helped create the sex segregated job market, with the more lucrative positions reserved for men.[2/] By defining a job as requir-

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1/ See Women's Bureau, U.S. Dep't. of Labor, Summary of State Labor Laws for Women (1969), reprinted in Hearings on S.J. Res. 61 Before the Subcomm. on Const. Amendments of the Senate Comm. on the Judiciary, 91st Cong., 2nd Sess. 729 (1970); Oldham, "Sex Discrimination and State Labor Laws," 44 Den. L.J. 344 (1967).

2/ See generally Blumrosen, "Wage Discrimination, Job Segregation and Women Workers," 6 Women's Rts. L. Rep. 19 (1979-80); Ross, Sex Segregation and "Protective" Labor Legislation, reprinted in Hearings on S.J. Res. 61 Before the Subcomm. on Const. Amendments of the Senate Comm. on the Judiciary, 91st Cong., 2nd Sess. 392 (1970). Furthermore, sex segregation in employment has not decreased and some indicators show it is actually increasing. See U.S. Comm'n on Civil Rights, Social Indicators of Equality for Minorities and Women (1978); U.S. Dept. of Labor, 1975 Handbook on Women Workers (1975).

ing overtime, night work, or heavy lifting, employers could completely disqualify women. Maximum hour laws denied women higher paid overtime work. Finally forced maternity leaves denied women work and seniority.[3/] These "protective" laws gave women the option of staying at home or taking employment in lower paid, less desirable jobs.

Employment was only one of the areas in which courts used biological differences to sanction laws denying women the rights and responsibilities

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3/ See e.g. the policies struck down in Nashville Gas Co. Tenn. v. Satty, 434 U.S. 136 (1977); Cleveland Board of Education v. LaFleur, 414 U.S. 632 (1974).

of male citizens. Women and the blind were given special "protection" by a Georgia statute requiring payment of a poll tax.[4/] "In view of the burdens necessarily borne by them for the preservation of the race, the State reasonably may exempt them [women] from poll taxes." Breedlove v. Suttles, 302 U.S. 277, 282 (1937). Unlike the blind, however, women were only exempt if they did not register to vote. The statute alleviated the tax burden by discouraging women from participating in the political process.

[4/] The poll tax is now illegal by judicial decision, Harper v. Virginia State Brd. of Elections, 383 U.S. 663 (1976) and constitutional amendment, U.S. Const. amend XXIV.

Biology justified the exemption of women from jury duty. Finding that "woman is still regarded as the center of home and family life", this Court upheld a Florida statute automatically excluding women from serving on juries unless they registered with the court clerk. Hoyt v. Florida, 368 U.S. 57, 62 (1961). As recently as 1970 lower Federal courts upheld such exemptions. Following Hoyt, a Federal district court explained: "Granted that some women pursue business careers, the great majority constitute the heart of the home, where they are busily engaged in the 24 hour day task of producing and rearing children, providing a home for the entire family, and performing the

daily household work ..." Leighton v. Goodman, 311 F. Supp 1181, 1183 (S.D.N.Y. 1970).

Woman's role as a potential childbearer and childrearer justified a separate set of rights and responsibilities. Women were seen primarily responsible in the private sphere of home and family, while men's responsibilities were in the public sphere. Biological differences have been used to perpetuate an invidious system of discrimination against women. Under the banner of "protection" the law has justified a dual system of rights which prevented women from equal access to and participation in the public sphere in the glorification of motherhood.

Today, however, this Court rejects laws that create separate spheres for men and women by firmly and repeatedly affirming the Constitutional right to sex based equality under the law. See, most recently, Mississippi University for Women v. Hogan, supra. Since 1973 this Court has also affirmed that the Constitutional right to privacy prevents the state from denying women, and their physicians, access to the safe and legal abortion services that are essential to women's capacity to live as free, equal and autonomous citizens. See e.g., Roe v. Wade, 410 U.S. 113 (1973); Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

II. Laws Restricting Access to Reproductive Health Services Impose Enormous and Disproportionate Burdens on Women.

Only women bear the physical burdens of pregnancy. These burdens range from minor discomfort to permanent damage to health to loss of life.[5/] When the state acts to restrict access to reproductive health services pregnant women are compelled to endure this physical invasion and the physical, psychological, and socio-economic consequences of it.

The value which the common law and constitution attach to the indivi-

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5/ G. Bourne and D. Danforth, Pregnancy (rev. ed. 1975). For an excellent summary see Regan, "Rewriting Roe v. Wade," 77 Mich L. Rev. 1569, 1579-83 (1979).

dual's right to control his or her own body is so high that people are not generally required to reach out to aid another, even when it is possible to save another person from grave injury.[6/]

6/ W. Prosser, The Law of Torts §56 (4th ed. 1971) 340-341.

> Consider a simple burning building, with a child trapped inside. Would a court impose criminal liability on anyone, even the child's parent, who did not attempt to save the child at the risk of second-degree burns over one or two percent of his or her body? . . . (A)n innocent life can be saved by a physical invasion comparable to or less than pregnancy and delivery. . . (E)ven if the potential rescuer is specified to be the child's parent, liability is unlikely. In all other cases, the suggested imposition is unthinkable in the context of our legal system.

Regan, "Rewriting Roe v. Wade," supra n.5 at 1558.

Laws restricting access to abortion impose upon one class of people, women, uniquely onerous obligations to endure physical intrusion to aid another.[7] By restricting abortion and forcing

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[7] It is not possible to say that a pregnant women voluntarily assumes a duty to aid the fetus. No method of contraception is entirely effective. The one year failure rates for various methods of contraception range from 2% for pills to 10% for diaphrams and condoms to 40% for douche. R. Hatcher, et. al. Contraceptive Technology, 1982-1983 (11th Rev. Ed. 1982).

An assertion that women, by engaging in sex, voluntarily assume a duty to aid the fetus depends on the archaic, reprehensible, and constitutionally indefensible notion that women, but not men, may be punished for their sexual activity, and punished by being forced to bear a child. Eisenstadt v. Baird, 405 U.S. 438 (1972); Carey v. Population Services Intl., 431 U.S. 678 (1977).

a woman to carry a fetus to term, the state demands that women tolerate the most intrusive form of physical invasion of their bodies. The right to freedom from this type of physical intrusion has long been a part of our legal heritage:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control, of his own person ... Union Pacific Railway Co. 141 U.S. 250, 251 (1891).

Individual interests in freedom from state mandated intrusions on physical integrity are explicitly protected by the 13th Amendment's prohibition against involuntary servitude, the 8th Amendment's ban on cruel and unusual punishment, as well as the constitu-

tionally protected right to privacy.[8/]

The sexually differential impact of reproductive capacity is not limited to pregnancy itself. When reproductive health services are restricted, all heterosexually active women know that their life may be interrupted at any time by the short and long range risks

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8/ The constitutional right to privacy affirmed in Roe v. Wade has deep and strong historic roots. 410 U.S 113, 152 (1973). It prohibits laws restricting access to abortion, unless they are narrowly designed to serve compelling state purposes. This constitutional requirement is appropriately more rigorous than the heightened scrutiny demanded of ordinary sex based classifications; the enormity of the burdens that unwanted pregnancy imposes upon women and the centrality of control of reproductive capacity to women's equality as citizens, workers and human beings require no less.

and burdens of pregnancy.[9] This in turn profoundly affects the ability of

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[9] In Michael M. v. Sonoma County, 450 U.S. 464, 471 (1981) this Court recognized that pregnant women and girls confront:

> problems more numerous and more severe than any faced by her male partner. She alone endures the medical risks of pregnancy or abortion. She suffers disproportionately the social, educational, and emotional consequences of pregnancy.

In that case the Court found that the sexually disproportionate burdens which unwanted pregnancy imposes on women are so severe that the rigorous equal protection standard had been met, even though the fit between the sex based classification defining the crime of statutory rape and the objective of avoiding unwanted pregnancy was extremely tenuous. Here by contrast there is a direct, demonstrable relationship between state created barriers to abortion and severe, predictable injury to women.

women to plan their lives. By exacerbating this uncertainty, restrictions on reproductive health services pervasively undermine the ability of women to achieve and contribute in wage work and public life.

Technology sometimes allows human beings to transcend the limits of biology. We fly. We visit anartica and space. Advances in human understanding, science and medicine allow people greater control of reproductive capacity. When the state denies women access to reproductive health services, it is not nature, but the state, that prevents them from approaching the capacity for personal autonomy that

has traditionally been the perogative of men.[10/]

10/ Kenneth Karst, "Forward: Equal Citizenship Under the Fourteenth Amendment," 91 Harv. L. Rev. 1, 57, n.320 (1978) notes, "Only a lawyer (a male lawyer) could regard . . . laws (regulating pregnancy, abortion and contraception) as sex neutral."

Laurence Tribe, American Constitutional Law, (1978) p. 924, observes:

> If a man is the involuntary source of a child-if he is forbidden, for example, to practice contraception-the violation of his personality is profound; the decision that one wants to engage in sexual intercourse but does not want to parent another human being may reflect the deepest of personal convictions. But if a woman is forced to bear a child-not simply to provide an ovum but to carry the child to term-the invasion is incalculably greater. Quite apart from the physical experience of pregnancy itself, an experience which of course has no analogue for the male, there is the

(Footnote continues on following page)

III. The Restrictive Abortion Regulations Challenged Here, Single Out Abortion From All Other Medical Services, Impose Requirements That Perpetuate Destructive, Inaccurate Stereotypes of Women, And Coerce Women to Accept Their Maternal Destiny.

The constitutionally protected right to privacy prevents the state from restricting access to abortion, prior to viability, unless the state demonstrates that restrictions are narrowly designed to serve compelling interests in the promotion of maternal health. Roe v. Wade, 410 U.S. at 162-63. The restrictive regulations challenged here are not justi-

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> attachment the experience creates, partly physiological and partly psychological, between mother and child. Thus it is difficult to imagine a clearer case of bodily intrusion, even if the original conception was in some sense voluntary.

fiable in relation to maternal health. Their purpose and effect is to demand the sacrifice of the health and well being of the woman.

All of the laws challenged in these three cases impose requirements for abortion that are very different from the legal restraint normally applicable to other medical procedures. For example the Akron and Missouri laws require that prescribed information be conveyed, that the women wait, 24 hours in Akron and 48 hours in Missouri, after receiving the required information, and that the information be communicated by the physician. These requirements, like all the restrictions challenged in these cases, are enforced by imposing

criminal sanctions against the physician. These special requirements for abortion are all premised upon and perpetuate an inaccurate stereotype of women as incompetent, dependent upon male authority and incapable of moral decision making.

We support general requirements that written consent be obtained prior to any medical procedure, including abortion. Planned Parenthood v. Danforth, 428 U.S. 52, 65-67 (1976). Tort law requires consent prior to medical treatment, and, in most jurisdictions demands that the physician provide that information which a reasonably prudent person would want in deciding whether to undergo the proposed treatment. See e.g. Canterbury

v. Spence, 464 F.2d 772 (D.C. Cir.), cert denied, 409 U.S. 1064 (1972). At the heart of the informed consent requirement is the recognition, eloquently expressed by Benjamin Cardozo in 1914, that "every human being of adult years and sound mind has a right to determine what shall be done with his own body." Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129, 105 N.E.2d 92, 93 (1914). In 1976 Ohio codified the common law informed consent requirement, providing immunity from civil liability to doctors who use a consent form setting:

> forth in general terms the nature and purpose of the procedure, together with known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss of function of any organ or limb, or disfiguring scars

> associated with such procedures, with the probability of each such risk if reasonably determinable.

The general Ohio consent law also requires acknowledgment "that all questions asked about the procedure have been answered in a satisfactory manner." Ohio Rev. Code Ann. §2317.54 (1976). Consent to treatment is presumed to be legally valid if it meets these general requirements.[11/]

11/ Missouri common law requires that ". . . the patient is entitled to such information as he needs to make an intelligent decision and to give an informed intelligent consent." Roberson v. Menorah Medical Center, 588 S.W.2d 134, 137 (Mo. Sup. Ct. 1979). Doctors must provide such information as other physicians convey in comparable situations. Aiken v. Cleary, 396 S.W.2d 668, 674 (Mo. Sup. Ct. 1965).

The special abortion consent laws are constitutionally objectionable in that the explicit information required to be conveyed assume and perpetuate an inaccurate stereotype of women as incapable of moral decision-making. The Akron ordinance demands that she be told "that the unborn child is a human life from the moment of conception," and Missouri requires that she be informed of the "anatomical and physiological characteristics of the unborn child." A woman who experiences an unwanted pregnancy must make a decision. A woman who believes she is pregnant does not seek abortion services from a clinic or private physician, until and unless she makes a moral and personal choice to

terminate the pregnancy. The decision normally proceeds action to effectuate it.12/

12/ The trial court in Missouri found as a matter of fact on the basis of expert testimony "that, as a general proposition, women seeking abortions have completely thought out the abortion decision prior to approaching a clinic or personal doctor." Planned Parenthood Ass'n of Kansas City v. Ashrcoft, 483 F. Supp. 679, 696 (W.D. Mo. 1980)

Most abortions are provided in a relatively small number of large facilities. In 1980, 76% of abortions were performed in clinics serving 1000 or more abortion patient during the year. S. Henshaw, et. al., "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5, 10 (1982). The most common reason women offer for the decision to have an abortion is that they "would not be able to give a child a fair chance at this time." This was cited by over 80% of women seeking abortions. L. Shusterman, "Predicting the Psychological Consequences of Abortion," 13A Soc. Sci. & Med. 683, 686 (1979).

This Court recognized in Roe v. Wade that "those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus," as to when human life begins, and that there is a "wide divergence of thinking on this most sensitive and difficult question." 410 U.S. 160-61. These laws reflect a false and demeaning presumption that the state and the physician are more competent to make this moral decision than is the woman.

The laws also reflect an inaccurate stereotype of women as incompetent to make practical choices. Akron commands the physician to inform the woman that "numerous public and private agencies and services are available to assist

her during the pregnancy and after the birth of her child," and Missouri law requires that she be given a list of such services. The physician and the state are not in a better position than the woman to evaluate the "public and private agencies and services" available to help her if she should bear a child.[13/] As Justice Stevens

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13/ The reality is that for many women the birth of a child condemns them to continued, desperate poverty. The American Promise: Equal Justice and Economic Opportunity, the Final Report of the National Advisory Council on Economic Opportunity (1981) documents that during the 1970's "more of the poor were women, and more women, especially those heading families with minor children, became poor." Inadequate public and private support services impose an "unusual amount of stress" on poor women that "exacts a toll on their physical and emotional health." Id. at p. 7.

observed, in discussing parental involvement in a minor's decision making, "the most significant consequences of the decision are not medical in character. . ." Bellotti v. Baird, 428 U.S. 132, 103 (1976). The abortion decision is profoundly moral and personal, as well as medical. The special consent laws for abortion both reflect the stereotype of woman as incapable of making significant life choices and attempt to force her to fulfill the "noble and benign" mission of motherhood.

The informed consent provisions do not treat the woman as a human being with a "right to determine what shall be done with her own body," but rather as confused and disoriented.

The ordinance requires that the doctor inform her that abortion "may leave unaffected" any psychological problems she may have. A law requiring the communication of information as self-evident and frivolous as this does not treat the woman as a competent person.

The requirements that the women wait, 24 hours in Akron and 48 hours in Missouri, after receiving the prescribed information ratify archaic stereotypes about the changability and indecisiveness of women. The trial courts below found that the waiting period "requires the patient to make two trips to the clinic instead of one," with attendant increases in travel, child care, and work loss

expenses.[14/] As the Circuit Court recognized in the Akron case, the "unstated" purpose of the mandatory waiting period is "to require a 'cooling off period' during which second thoughts might come into play." 651 F.2d at 1208.

14/ Akron Ctr. for Reproductive Health v. City of Akron, 479 F. Supp. 1172, 1204-05; the waiting period "has, in fact, a detrimental effect on the health interests of women seeking abortions and . . . is unduly burdensome. . . " Planned Parenthood Ass'n of Kansas City v. Ashcroft, 483 F. Supp 679, 696. All the Circuit Courts that have considered fixed mandatory waiting periods after counseling and before abortion have found no medical justification for the inflexible waiting requirement. See Akron Center, 651 F.2d at 1208; Ashcroft, 655 F.2d 848, 866; Charles v. Carey, 627 F.2d 722, 785-86 (7th Cir. 1980); Planned Parenthood League of Mass. v. Bellotti, 641 F.2d 1006, 1014-16 (1st Cir. 1981).

As we have noted, the abortion decision normally proceeds action seeking an abortion. What then is the purpose of singling out this service, and demanding that women "think twice "? The waiting period embodies and perpetuates the classic stereotype of the changeable woman.[15/] The waiting period exacts substantial costs in terms of time, convenience, travel, and money; it inevitably in-

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15/ Virgil tells us "A woman is always a fickle, unstable thing." Francis I of France explains, "Woman often changes; foolish the man who trusts her." The poet, Aaron Hill says, "First, then, a woman will or won't, depend on it." Alexander Pope opinioned, "Women's at best a contradiction still." J. Bartlett, Familiar Quotations, pp. 118, 400, 407 (14th ed. 1968.)

creases medical risk. A law causing concrete harm to women and supported by nothing but sex based stereotypes cannot stand. Stanton v. Stanton, supra; Orr v. Orr, supra; Mississippi University for Women v. Hogan, supra.

The requirement of the Akron and Missouri laws that the physician personally communicate this prescribed information is also demeaning to the woman. As we have seen, some of the information required is trivial or untrue; much of it does not relate to medicine or physical or emotional health, but rather to misplaced moral and social concerns. A law denying the physician's normal authority to delegate educational and communication tasks to others increases the

cost of the abortion. It has no effect other than to restrict access to abortion and to deny the decision making competence of the woman patient.

Finally, the restrictive laws challenged in these three cases impose criminal penalties upon physicians who fail to comply with their mandate. Ordinary tort principles of informed consent treat the doctor/patient relationship as a private one; the doctor's superior knowledge, authority and skill give rise to the duty to provide information, but the law leaves enforcement of this duty to private agreement and civil action. Criminal sanctions provide special "protection" for women seeking abortions. As has so often been true of laws providing "special

protection" for women, these policies reflect "an attitude of 'romantic paternalism' which, in practical effect, put women not on a pedestal but in cage." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). Doctors who do not wish to confront the Hobson's choice of either personally communicating information they believe to be false or risking punishment as criminals can simply abstain from performing abortions. The shortage, in many areas total unavailability, of physicians willing and able to perform

abortions is exacerbated.[16/] In the name of providing women "special protection" from uninformed decision-making, these laws create often insurmountable obstacles to effectuation of the women's choice. Laws mandating criminal punishment for doctors who fail to communicate information that many might reasonably believe to be false impermissibly "confine the attending physician in an undesired and uncom-

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16/ In 1980, 78% of all U.S. counties had no identified provider of abortion services. S. Henshaw, "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5, 5 (1982). Only about 10% of obstertrician-gynecologists in private practice perform abortions in their offices. Id. at 12. Only 17% of public hospitals and 34% of private, general non-Catholic hospitals reported any abortions performed in 1980. Id. at 11.

fortable straightjacket in the practice of his profession." Planned Parenthood v. Danforth, 428 U.S. 52, 67, n. 8 (1976).

Each of these three cases also challenges the requirement that abortions performed after the 12th week of pregnancy be done in the hospital. In every other medical situation, competent adults, in consultation with their physicians are free from state constraint in choosing whether medical treatment requires hospitalization.[17/] The physician and patient choice whether or not to use hospital facilities is influenced by medical

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17/ See generally Curran and Shapiro, Law, Medicine and Forensic Science, Ch. 5 and 6 (1982).

factors, personal convenience, the availability of hospital facilities, and cost. In no other situation does the state demand that medical treatment be restricted to the hospital. Forcing women seeking abortions to use hospital facilities again reflects and reinforces the stereotype of women as incompetent, and in need of uniquely special state "protection."

The second trimester hospitalization requirement plainly has the practical effect of putting women, "not on a pedestal, but in a cage." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). The evidence presented in each of these cases, confirms general data, showing that in most areas of the country there are no

hospitals in which second trimester abortions may be performed.[18/] So, in the name of "protecting" women from the dangers of out-patient abortions in the second trimester, these laws force women to travel to areas where hospitals are available or where doctors are legally free to exercise their own medical judgment that hospitalization is unnecessary. The "protection" of women imposes upon them enormous financial and emotional

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18/ Supra n. 16. Among the seriously limited number of hospitals providing any abortion services, 30% allow abortions only to women at 10 or fewer weeks gestation. Only 21% of hospitals allowing abortions will do so after 14 weeks gestation. S. Henshaw, et. al. "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5, 14-15 (1982).

costs, and increases risks to life and health as a result of the inevitable delay. Many women are unable to pay the price that the state exacts for their "protection," and will hence be forced to continue their pregnancy.

Because of our pervasive history of harming women through laws designed to provide them special protection, the Court has often held, and recently eloquently reaffirmed that if the objective of a law is to "'protect' members of one gender because they are presumed to suffer from an inherent handicap or to be innately inferior, the objective itself is illegitimate." Mississippi University for Women v. Hogan, 50 U.S.L.W. 5068, 5070 (1982). In a world in which no state "protects"

its citizens from unwisely choosing outpatient medical services, the special "protection", which the second trimester requirements provide exclusively for women seeking abortions, reflect and reinforce the assumption that women are "innately inferior" in their capacity to make appropriate medical decisions, in consultation with their physician. The lack of medical justification for the flat requirement that second trimester abortions be performed in the hospital[19] simply confirms that the

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19 Planned Parenthood, et. al. v. Ashcroft, 664 F.2d 687 (8th Cir. 1981) reviews the data and concludes that the hospitalization requirement for second trimester abortions under-

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purposes of these policies are to reinforce the stereotype of women as people who suffer from an "inherent handicap," and to force them to fulfill their "paramount destiny" as mothers.

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mines women's health interest. The Sixth Circuit in Akron Center, etc. v. City of Akron, 651 F.2d 1198, found that evidence established the safety of outpatient procedures in the second trimester, and that the hospitalization requirement placed a significant burden on access to abortion, but nonetheless believed that this Court's summary affirmance of Gary-Northwest Indiana Women's Services v. Bowen, 451 U.S. 934 (1981) precluded a finding that the burdensome requirement was unconstitutional. See also Margaret S. v. Edwards, 488 F.Supp. 181, 193 (E. D.La. 1980), striking a hospitalization requirement as detrimental to women's health.

CONCLUSION

For the reasons stated above, amici respectfully submit that the judgment of the Eighth Circuit Court of Appeals should be affirmed, the judgment of the Sixth Circuit Court of Appeals should be affirmed in all respects except its holding that the constitutionality of the hospitalization requirement was forclosed by this court, and the judgment of the Supreme Court of Virginia should be reversed.

Respectfully submitted,

NADINE TAUB
15 Washington St.
Newark, N.J.

SYLVIA A. LAW
40 Washington Sq. So.
New York, N.Y. 10012

ELLEN J. WINNER
Rabinowitz, Boudin, Standard
Krinsky and Leiberman
30 East 42nd Street
New York, N.Y. 10017

Counsel gratefully acknowledge the assistance of Nancy Miller and Vicki Van Fleet.

Amicus Brief

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No. 81-185

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM 1981

CHRIS SIMOPOULOS, APPELLANT

vs.

COMMONWEALTH OF VIRGINIA, APPELLEE

APPEAL FROM THE SUPREME COURT OF VIRGINIA

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE BY THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN

Alan Ernest
P.O. Box 2471
Washington, D.C. 20013
(703) 437-1178

Counsel for Amicus

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

The Court is moved for leave to file the attached brief amicus curiae by The Legal Defense Fund For Unborn Children.

The interest of the amicus is described in the attached brief.

The amicus curiae brief is not in support of either party. The purpose of the amicus is to defend the constitutional right to life of the unborn, which the parties have not done. The amicus demonstrates that the U.S. Supreme Court has already overruled Roe v Wade, 410 U.S. 113, and that mere argument that these killings can continue without question can be criminally prosecuted. The amicus addresses no arguments to the issues raised by the parties; but the facts and authorities presented by amicus dispose of all the issues raised by the parties.

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Alan Ernest
Counsel for Amicus

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AMICUS CURIAE BRIEF BY THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN

Interest Of Amicus Curiae

The Legal Defense Fund For Unborn Children is an organization whose purpose is to protect the constitutional rights of children unborn and born alive. The parties have not done this. This brief is not in support of either party.

Summary of Argument

The amicus curiae submits evidence not submitted by the parties, to show that Roe v. Wade is a mistake of law. The Roe v Wade killings violate the Fifth and Fourteenth Amendments of the U.S. Constitution. Any Justice who takes part in these killings can be criminally prosecuted. One of the giant homicidal frauds in the history of the world has been perpetrated on the American republic. The dagger of the assassin has been concealed beneath the robe of the jurist. This court has already overruled Roe v Wade, and must now do it expressly.

Argument

I. ROE v WADE IS BASED ON FALSE EVIDENCE, AND THE VICTIMS ARE BEING EXTERMINATED IN VIOLATION OF THE U.S. CONSTITUTION.

The evidence, summarized below, proves that the Court's conclusion in Roe v Wade, 410 U.S. 113, 158, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," is based on a fatal reversal of the burdens of proof and persuasion, and indispensable parts of the Court's evidence are fabricated and false. The evidence establishes, beyond the legal power of any federal judge to deny, that the unborn are persons whose lives are protected by the Fourteenth Amendment, as follows:

A.

Even the Court admitted in Roe v Wade, 410 U.S. at 156-157, that if the unborn were "a 'person' within the language and meaning of the Fourteenth Amendment," then the case for a constitutional right to kill the unborn, as claimed in Roe v Wade, "of course collapses, for the fetus' right to life would then be guaranteed specifically by the Amendment."

B.

The terms of the Fourteenth Amendment ("nor shall any state deprive any person of life ... without due process of law")(emphasis added) are "universal in their application." Yick Wo v. Hopkins, 118 U.S. 356, 369 (1886). The words "any person" admit of no exceptions whatever. Thus, on their face, the words "any person" include the unborn, as everyone else.

C.

The holdings of Chief Justice Marshall show that the Supreme Court had no lawful power to construe an exception to express, universal terms (such as "any person") unless the Court can show that "the absurdity and injustice of applying the provision to the case, would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application."[1/] And the Court must further prove that "had this particular case been suggested " to the framers, "the language would have been so varied as to exclude it."[2/]

1./ Sturges v Crowninshield, 4 Wheat. 122,202-3.
2./ Dartmouth College v Woodward, 4 Wheat.518,644-5.

Chief Justice Marshall founded the universality of the Supreme Court's jurisdiction on these very rules. 3/

The Court thus bore a very extraordinary evidentiary burden before it could create an exception to the universal terms "any person" so that victims could be killed in violation of positive criminal statutes. 4/

3./ Cohen v Virginia, 6 Wheat. 264, 378-380.

4./ The truth of this extraordinary evidentiary burden can be demonstrated by applying it to various cases. Before the Court could create an exception to the universal terms "any person" so that Jews, or Catholics, or the insane, could be killed like the unborn, the Court would have to demonstrate that "the absurdity and injustice of applying the provision [the terms- "any person"] to the case [the case of - Jews, Catholics, or the insane],would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application." Sturges v. Crowninshield, supra. And the Court must prove that if the case of the Jew, Catholic, or the insane had been suggested to the framers of the Fourteenth Amendment, then "the language would have been so varied, as to exclude it." Dartmouth College v. Woodward, supra. The framers would have changed the words of the Amendment to read that "No state shall deprive any person, except Jews, Catholics or the insane, of life ... without due process of law."

These same extraordinary evidentiary burdens must universally apply to all groups whose personhood may be challenged, including the unborn. Thus the Court bore the heaviest evidentiary burden possible in constitutional interpretation in order to create an exception to the universal terms "any person" so the unborn could be killed for any reason, or no reason, in violation of positive criminal statutes.

D.

The Supreme Court presented false evidence in Roe v Wade to support its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. And, but for the false evidence, there is not even a credible foundation, much less a compelling one, for denying the protection of the express, universal terms "any person" to the life of the unborn.[5/]

5./Summary of False Evidence:

In introduction, at the time the Fourteenth Amendment was adopted in 1868, most states had already enacted positive statutes that made abortion a crime unless it were necessary to save the life of the mother. Within a few years, these criminal abortion statutes were virtually universal.

Consequently, any theory of a constitutional right to abortion on demand faced an impossible contradiction: How is it possible that the people who adopted the Fourteenth Amendment had enacted positive criminal statutes to protect unborn life, but, at the same time, without a single word of explanation, intended to imply an exception to the express, universal terms that not "any person" can be deprived of life without due process of law, and to create a constitutional right to kill the unborn?

To resolve that fatal contradiction, the Court asserted the hypothesis that when the criminal abortion statutes were first enacted, the laws were not intended to protect unborn life, but rather were

only intended to protect the mother. This hypothesis was falsely fabricated and used as follows:

A.

The Supreme Court first asserted, "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman." Roe v Wade, 410 U.S. at 148. This was asserted as fact.

The only authority cited by the Supreme Court to prove this assertion of fact was a 20th century medical history book, Haagensen and Lloyd, A Hundred Years of Medicine 19 (1943), cited in Roe v Wade, supra, at 148n.43. But this book merely described the hazards of major surgery in general prior to Lister's discovery of antiseptics. The reference did not even mention the abortion operation.

However, the 19th century obstetric authorities throughout the Western world prove the Court's assertion of fact to be false. These 19th century obstetric authorities, based upon their own experience in performing abortions, and from hundreds of cases reported from around the world, declared in their obstetric textbooks that the abortion operation, the operation of artificially evacuating the fetus from the womb, was "perfectly safe" to the mother, 2 T. Denman, M.D., An Introduction to the Practice of Midwifery 96 (1802)(English physician); or "experience has proved that the dangers of the operation are reduced to a small matter," A.L.M. Velpeau, M.D., A Complete Treatise on Midwifery 530 (4th Am. ed. 1852)(French physician); or "to the mother there is very little danger." H.L. Hodge, M.D., The Principles and Practice of Obstetrics 293 (1864)(American physician). In short, the 19th century obstetric authorities prove the Supreme Court's assertion of fact to be false.

of proof and persuasion, as set out in the holdings of Chief Justice John Marshall. See pages 3-4, supra. Instead of the burden of

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The Supreme Court never revealed the "hazardous" abortion "procedure" to which it was referring. Actually, the 19th century physicians used the ancient method: "the membranes of the ovum are punctured," which permitted "the discharge of the waters," which induced the "action of the uterus" to "come on," which resulted in the expulsion of the fetus from the womb. 2 Denman, supra, 99. One 19th century physician traced this operation back almost 2000 years. F. Ramsbotham, M.D., The Principles and Practice of Obstetric Medicine 724 (4th ed. 1856).

Consequently, the 19th century physicians were using an ancient abortion operation which they described as not hazardous to the woman. The Supreme Court did not examine even one 19th century obstetric textbook. And the medical textbooks prove its assertion of fact, "When most criminal laws were first enacted, the procedure was a hazardous one for the woman," to be false.

B.

The Supreme Court next asserted, "Abortion mortality was high." Roe v Wade, 410 U.S. at 149. This is asserted as fact.

The Supreme Court asserted "Abortion mortality was high," without any authority to support it. It was a naked assertion. The 19th century obstetric authorities also prove this assertion of fact to be false. The medical authorities, supra, expressly asserted that the abortion operation was not deemed to be hazardous to the mother.

Consequently, the Court's assertion that "Abortion mortality was high" is false.

C.

Upon the two false assertions of fact, the Court falsely infers that"a State's real concern in enacting a criminal abortion law was to protect the

proving that including the unborn within the terms "any person" would "be so monstrous, that all mankind would, without hesitation, unite in rejecting the application," the

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pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy." Roe v Wade, 410 U.S. at 149. Thus a false inference was drawn from false facts.

D.

From the false inference that the criminal abortion laws were not intended to protect the lives of the unborn, the Court falsely inferred that, likewise, the framers of the Fourteenth Amendment did not intend it to protect the lives of the unborn, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. This false conclusion is drawn from a false inference which is drawn from false facts.

Moreover, as independent corroboration of the purpose of the criminal abortion statutes to protect the unborn, 19th century authorities in criminal law, e.g., 2 Archbold, Archbold's Criminal Procedure, Pleading and Evidence 295 (6th ed. 1853); medical jurisprudence, e.g., F. Wharton and M. Stille, M.D., A Treatise on Medical Jurisprudence 339, 927(2d ed. 1860); medicine, e.g., 12 Transactions of the American Medical Association 27-28(1860); as well as state supreme courts, e.g., State v Moore, 25 Iowa 128, 131, 135-36(1868), leave no doubt that these 19th century abortion laws were intended to protect the lives of the unborn. Consequently there is no other body of evidence to come to the Court's rescue.

CONCLUSION

The Supreme Court bore the burden of demonstrating, beyond a doubt based on reason, that the absurdity and injustice of including the unborn within the

U.S. Supreme Court fatally reversed the burden. The Court placed the burden on the unborn to prove with "assurance" (that is, to make certain and put beyond doubt) that they were persons within the terms "any person," or the unborn would be excluded from the terms "any person." Rather the burden was on the Supreme Court to prove

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terms "any person" would be "so monstrous, that all mankind would, without hesitation, unite in rejecting the application," Sturges v Crowninshield, supra. And the Court had to prove to a demonstration that if the case of the unborn had been presented to the framers and adopters of the Fourteenth Amendment, "the language would have been so varied as to exclude it." Dartmouth College v Woodward, supra.

But, the Supreme Court did not cite even one single 19th century authority that expressly agreed with its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," much less one that asserted that there was a constitutional right to kill the unborn, as set out in Roe v Wade. And the court's assertion that the 19th century abortion laws were not intended to protect the lives of the unborn is shown to rest on false evidence.

The legal history demonstrates that the people who framed and adopted the Fourteenth Amendment not only intended it to protect the lives of the unborn, but these people had already enacted criminal abortion laws to do so in fact. This case for the unborn is absolutely conclusive. The terms "any person" must include the unborn.

with "assurance" that the unborn were not included within the terms "any person" or they would be included.[6/] And the evidence for the unborn is far stronger than that for many groups which the Court has judicially recognized to be included within the uni-

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6./ The Court illegally switched the burdens of proof and persuasion in the following manner. The Court first decreed a constitutional right to kill the unborn. Roe v Wade, 410 U.S. at 153. Incredibly, subsequently, the Court examined the question of the personhood of the unborn under the Fourteenth Amendment. Thus, in accordance with its compelling state interest test, once the constitutional right to kill the unborn was established, the burden was on the unborn to demonstrate the compelling justification of the criminal abortion statutes; that is, the burden was on the unborn to affirmatively prove that they were persons within the meaning of the terms "any person" in the Fourteenth Amendment- or be excluded.

Moreover, the objections which the Court raised to defeat the personhood of the unborn in Roe v Wade, 410 U.S. at 156-158 were either false, or irrelevant. This evidence will be submitted to the Court on request. The Court exactly perceived its function as that of a criminal defense lawyer who only has to raise doubts about the prosecution case to win. But the Court cannot exclude anyone from the protection of the words "any person" by merely working up quibbles or "inconsistencies." Roe v Wade, supra, 158 n.54.

Could the Court first decree a constitutional right to kill Jews? And then place the burden on the Jews to affirmatively prove that they are included within the terms "any person"? And then, by quibbling with the Jews' evidence, decide the Jews were not included within the terms "any person" so they could be hauled off to the graveyard?

versal terms "any person." 7/

The Supreme Court has exactly defied the express words "any person" in the Constitution, and their spirit, 8/ as well as the plain intention of the framers, 9/ and condemned to death those victims whom the Constitution endeavors to preserve.

7./ The Court was so certain that "corporations" were included within the terms "any person" that it forbade any oral argument to the contrary. Santa Clara v. So. Pac. RR, 118 U.S. 394,396. And the Court held that "strangers and aliens" were included within the terms "any person" by merely observing: "These terms are universal in their application." Yick Wo v Hopkins, supra, at 369.

8./ The uncontradicted scientific evidence in Roe v Wade showed that the unborn child "is alive," that the fetal heartbeat begins "pulsations at 24 days," and "brain waves have been noted at 43 days."

The Court itself has recognized that, while the Declaration of Independence is not law in itself, yet it is "the thought and the spirit, and it is always safe to read the letter of the Constitution in the spirit of the Declaration of Independence." Gulf, Colo. & S.Fe v Ellis, 165 U.S. 150, 159-160.

The undisputed scientific evidence proves that the unborn child has been "created" and thus endowed with an "unalienable" right to "life," and within the spirit of the terms "any person." The Court would amend the Declaration to read that "all men are created equal-except those created to die for the convenience of others."

9./ The evidence, supra page 5 n.5, shows that the adopters of the 14th Amendment not only intended the lives of the unborn to be protected by the terms "any person," but they had already enacted criminal abortion statutes to do so in fact.

II. THE U.S. SUPREME COURT HAS WILLFULLY USED UNCONSTITUTIONAL PROCEDURES TO EFFECT AND MAINTAIN THE ROE v WADE KILLINGS.

The Supreme Court willfully used unconstitutional procedures to effect the Roe v. Wade killings.[1/]

And the Supreme Court has subsequently decided many abortion cases on the merits, but willfully used unconstitutional procedures to maintain the killings, as follows:

1. The Supreme Court willfully refuses to

1./ Counsel did not especially represent the unborn in the District Courts in Roe v Wade and Doe v Bolton. And the Supreme Court denied Bolton's request to allow counsel to represent the unborn in the Supreme Court. Thus, counsel did not represent the unborn at any stage of the original proceedings.

The question of the personhood of the unborn under the Fourteenth Amendment came up for the first time in the original proceedings after the cases reached the Supreme Court. Since no group had ever been excluded from the protection of the Fourteenth Amendment so they could be killed, the original parties had no notice of the kind of evidence, or the burdens of proof and persuasion the Court would deem determinative. The first time the parties understood this was when Roe v Wade issued, and the victims were condemned to death. But the Court had taken judicial notice of numerous facts and factors which the original parties had not seen, much less cross-examined in a judicial proceedings. An original party asked permission to cross-examine the Court's evidence. But the Supreme Court would not allow its evidence to be cross-examined.

allow retained(no cost to taxpayers)counsel to represent the victims being killed; [2/]

2. The Supreme Court willfully refuses to allow the evidence in Roe v Wade, which it used to condemn the victims to death, to be cross-examined; [3/]

3. The Supreme Court willfully refuses to allow evidence to be presented on behalf of the victims being killed to establish their right to life under the U.S. Constitution.[4/]

The U.S. Supreme Court's own rulings on due process of law show these procedures to

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2./ Some of these cases are: Colautti v Franklin, 58 L Ed 2d 596, motion to allow counsel represent unborn denied 57 L Ed 2d 1131(1978); Anders v Floyd, 59 L Ed 2d 442, motion to allow counsel represent unborn denied 58 L Ed 2d 235(1978); Bellotti v Baird, 61 L Ed 2d 797, motion to allow counsel represent unborn denied 59 L Ed 2d 29(1979); Ashcroft v Freiman, 59 L Ed 2d 630, motion to allow counsel to represent unborn denied 59 L Ed 2d 630(1979); United States v. Zbaraz, 65 L Ed 2d 831, motion to allow counsel represent unborn denied 62 L Ed 2d 665-6(1980); Harris v. McRae, 65 L Ed 2d 784, motion to allow counsel represent unborn denied 63 L Ed 2d 775(1980); H.L. v. Matheson, 67 L Ed 2d 388, motion to allow counsel represent unborn denied 64 L Ed 2d 234 (1980).

3./ Supra Note 2.

4./ Supra Note 2.

to be unconstitutional[5] and criminal.[6]

5./ The U.S. Supreme Court has held that even in civil, non-judicial proceedings, where crucial deprivations are threatened, such as loss of welfare, due process guarantees (1) Notice; (2) the right to be heard and to present evidence; (3) the right to confront and cross-examine adverse evidence; (4) the right of representation by retained counsel; (5) the right of an independent decisionmaker; (6) the right to have a written statement by the decisionmaker of the evidence relied upon and the reasons for the determination. Goldberg v Kelly, 397 U.S. 254, 268-271(1970). In Re Gault, 387 U.S. 1(1967); Morrissey v. Brewer, 408 U.S. 471 (1972); Gagnon v Scarpelli, 411 U.S. 778 (1973); Viteck v Jones, 63 L Ed 2d 552 (1980). Since the unborn are being killed, there can be no question whatever that these elements of due process of law are guaranteed.

6./ The criminality of such process is evident. Could a judge use such procedures to legalize the killings of the insane, or Jews? These are effectively the same procedures cited by the Nuremberg Court in convicting the Nazi judges of criminal extermination. United States v Altstoetter(The Justice Case), 3 Trials of War Criminal Before the Nuernberg Military Tribunals 1046(1951).

Can it now be argued that a judge, who could not condemn even one Jew to death without counsel in a criminal case, could condemn all Jews in the United States to death without counsel by calling it a civil case and decreeing that the lives of Jews were not protected by the Constitution? A person cannot be deprived of life or liberty without due process of law, regardless of the description of the proceeding. The Constitution thus guarantees that any proceeding to determine if one is a person within the meaning of the Constitution must satisfy due process of law.

And any judge who willfully deprives any victims of constitutional rights under a guise of law can be criminally prosecuted. Imbler v. Pachtman, 424 U.S. 409 (1976).

III. THE U.S. SUPREME COURT HAS CONFESSED IN COURT TO GUILT OF CRIMINAL EXTERMINATION, INCLUDING MASS MURDER, AND THIS IS THE LEGAL EQUIVALENT OF THE EXPRESS OVERRULING OF ROE v WADE, 410 U.S. 113 (1973).

For the 68th time, the U.S. Supreme Court is accused in its own court with criminally exterminating millions of lives in violation of the U.S. Constitution, and 18 USC 242.[1/]

For the 44th time, the U.S. Supreme Court is accused in its own court with mass murder in violation of state and federal statutes.[2/]

For about the 48th time, the U.S. Supreme Court is accused in its own court with willfully using unconstitutional, criminal procedures to maintain the Roe v Wade killings.[3/]

But, year after year, the U.S. Supreme Court has not denied the charges, much less

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1./ Charges based on evidence, supra page 2.

2./ Charges based on evidence presented in MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE, incorporated herein by reference.

3./ Charges based on evidence, supra page 12. The evidence makes it plain why the U.S. Supreme Court is willfully using unconstitutional procedures to maintain the killings. The evidence proves, beyond the power of any federal judge to deny, that the charges are true.

attempted to prove the charges to be false. This silence year after year in the face of accusation, while the victims are being killed, amounts to a confession in court that the charges are true.[4/] This tacit admission that Roe v Wade is a mistake of law is the legal equivalent of the express overruling of Roe v Wade. Any judge or party who chooses to close his eyes on these

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4./Under "the tacit confession rule," McCormick on Evidence §§ 161, 270, failure to deny a charge is equivalent to a confession that the charge is true. 4 Wigmore, Evidence, §§ 1071-1072(Chadborn rev 1972). "Underlying the rule is the assumption that human nature prompts an innocent man to deny false accusations and consequently a failure to deny a particular accusation tends to prove belief in the truth of the accusation." McCormick, supra, §161. And the Supreme Court itself has consistently recognized this rule. "(T)he Court has consistently recognized that ... silence in the face of accusation is a relevant fact. .... Silence is often evidence of the most persuasive character." Baxter v Palmigiano, 425 U.S. 308, 319(1976). And the rule is ancient. As Socrates cross-examined at his trial over 2000 years ago, "you are silent and have nothing to say. But is this not rather disgraceful, and a very considerable proof of what I was saying." And again, "I may assume that your silence gives assent." Apology in Plato 41, 45 (Jowett trans. Classics Club 1942).

And concerning the Court's continuing silence year after year, "Silence gains more probative weight where it persists in the face of accusation, since it is assumed in such circumstances that the accused would be more likely than not to dispute an untrue accusation." United States v. Hale, 422 U.S. at 176.

unparalleled facts, and argues that the killings can continue without question, can be prosecuted for complicity in criminal extermination just as if he had encouraged the killings after Roe v Wade was expressly overruled.[5/]

5./ The Supreme Court asserted to legalize killings which violated positive criminal statutes, including murder statutes. If Roe v Wade is a mistake of law, then all the killings since 1973 can be criminally prosecuted. The ex post facto provisions of the U.S. Constitution do not apply to judicial decision which are a mistake of law. Ross v Oregon, 227 U.S. 150(1913). The general rule is that mistake of law is no excuse for breaking the law. Perkins, Criminal Law 920(2d ed. 1969). The narrow exception of reasonable reliance on a court opinion thereafter determined to be a mistake of law does not apply to homicide cases. Model Penal Code, Tentative Draft No. 4, Comments § 2.04, page 138. In any event, "after a warning," such as given herein, a defendant can not claim his reliance was reasonable. Id., at 138. And one can be criminally implicated in homicide by mere words of encouragement while the victims are being killed. Lafave and Scott, Criminal Law §§ 61,64(1972).

To illustrate the true status of Roe v Wade, suppose that a lawyer had accused "the supreme judge" of Nazi Germany of mass murder 50 times in court, but each time "the supreme judge" listened in silence and did not deny the charge and prove it false, and just continued the killings. Would such judicial conduct have warranted people in arguing that the killings could continue without question? The Nuremberg Court answered that question. Such argument amounts to criminal complicity in extermination.

Roe v Wade has been overruled. In the face of these unparalleled facts, one must literally gamble life and liberty to support it. Many states still punish mass murder with the death penalty.

CONCLUSION

The Supreme Court has perpetrated one of the giant homicidal crimes in history on the United States. And the corruption of a judicial system for the accomplishment of criminal extermination involves an element of evil which is not found in frank atrocities which do not sully the judicial robes. The dagger of the assassin has been concealed beneath the robe of the jurist.

By its conduct, the U.S. Supreme Court has overruled Roe v Wade, 410 U.S. 113. Mere argument that the killings can continue can be criminally prosecuted. To save innocent lives from extermination, and uninformed persons from prosecution, the Supreme Court must expressly overrule Roe v Wade.

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Alan Ernest
Counsel for Amicus

Supplemental Brief

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APPEAL FROM THE SUPREME COURT OF VIRGINIA

MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

ALAN ERNEST
P.O. Box 2471
Washington, D.C. 20013
(703)437-1178

Counsel for Movant

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Russell, A Treatise on Crimes and Misdemeanors (4th ed. 1865)..... 6

Taylor, Manual of Medical Jurisprudence (Penrose Am. Ed. 6th ed. 1866) 6-7

Wharton, A Treatise on the Law of Homicide in the United States (1855) 7

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The Fourteenth Amendment "Any Person" 8-9

MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

The Court is moved to allow Alan Ernest to represent the victims being killed by Roe v Wade, 410 U.S. 113, as counsel or guardian ad litem.

Interest of Counsel

Alan Ernest is a lawyer in the District of Columbia and a member of the bar of this Court. His interest is to defend the constitutional right to life of the children unborn and born alive being killed pursuant to Roe v. Wade. The parties have not done this.

This is effectively a motion to allow retained counsel to represent the victims being killed, since there will be no expense to this Court, or to the taxpayers.

Summary of Argument

In Roe v Wade, the Court asserted to legalize killings which had been defined as murder since long before the adoption of the Fourteenth Amendment. Thus, Roe v Wade is no law at all, and should be expressly overruled.

This will dispose of all the issues raised by the parties.

The victims being killed are entitled by the U.S. Constitution to be especially represented by retained(no cost to taxpayers) counsel who has authority to cross-examine the evidence in Roe v Wade, which the Court used to condemn the victims to death, and to present evidence on their behalf to establish their right to life under the U.S. Constitution.

It can not be pretended that it is any longer the government of the United States, or any government of Constitution and laws, wherein judges Hitler-like assert to legalize mass murder, and then maintain the killings by willfully refusing to allow retained counsel to represent the victims being killed and defend their right to life protected by the Constitution.

The amicus curiae brief by the Legal Defense Fund For Unborn Children filed herein is incorporated by reference.

ARGUMENT

ROE v WADE IS NO LAW AT ALL, SINCE THE COURT HITLER-LIKE ASSERTED TO LEGALIZE KILLINGS DEFINED AS MURDER SINCE LONG BEFORE THE ADOPTION OF THE FOURTEENTH AMENDMENT

Counsel presents new evidence herein,[1/] not presented by the parties, to show that many of the killings that the Supreme Court asser-

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1./ The new evidence was published in The Washington Post on September 12, 1979, under the caption "WASHINGTON LAWYER CHARGES U.S. SUPREME COURT WITH MASS MURDER," as set out below. That the charging evidence can be published in the dominant newspaper in the nation's capital, but, as the victims are being killed, the evidence can not even be heard in this Court, proves the complete criminal degeneracy of the judicial system. The newly discovered evidence shows the Court asserted to legalize killings defined as murder since before the adoption of the 14th Amendment.

SUMMARY OF ARGUMENT

MANY ROE v WADE KILLINGS ARE MURDER

The evidence shows that many of the killings permitted by Roe v Wade, 410 US 113(1973) were murder in 1868. Since the killings were murder in 1868, then absent a constitutional amendment, the killings are still murder, and Roe v Wade is not law at all.

ARGUMENT

1. Introduction to Evidence

The evidence presented herein shows that, at the time the Fourteenth Amendment was adopted in 1868, the unlawful killing, with malice aforethought, of a child born alive was murder. Killings of children born alive were not treated as a special category, as was abortion.

It is thus absolutely indispensable to examine what "born alive" meant in 1868. It is obvious that, if the life of a child born alive was protected by

ted to legalize in Roe v Wade, 410 US 113, had thereto been defined as murder. It is just as if the Court asserted a right to kill Jews. Obviously, absent a constitutional amendment, these killings are still murder. Justices who have presumed to permit these killings may now be facing the death penalty in very many states.

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the murder laws in 1868, then it is a person within the language and meaning of the Fourteenth Amendment.

The evidence shows that in 1868, born alive did not mean natural birth after nine full months of gestation; nor did it mean birth after viability, "that is, potentially able to live outside the mother's womb, albeit with artificial aid." Roe v Wade, 410 US at 160. If abortion resulted in a live but unviable child that died as a consequence of its not being able to survive outside the womb, it was murder and punishable by the death penalty.

The evidence shows that the hysterotomy is a common method of performing abortions under Roe v Wade. This is essentially a Caesarean in which a live but unviable child is removed from the womb and left to die. The legal authorities show that in 1868, such a killing was murder, and punishable by the death sentence.

In summary, what was murder in 1868, can not now be decreed a constitutional right. Without an amendment to the Constitution, the killings must still be murder, and the Justices who permitted these killings may be guilty of mass murder in the first degree. This is still punishable by the death sentence in many states.

Many people would no doubt be astonished to learn that the case presented herein for the unborn is the very case they would have to present for themselves if their right to life were challenged. For example, take almost any group of persons, such as the insane, invalids, Jews or Catholics. Suppose it were claimed in federal court that the

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2. The English Law

The English law, as reflected in the writings of Coke(3 Inst. 50), Hawkins(1 Hawkins Ch. 13, s. 16) and Blackstone(4 Bl. Com. 198) defined the felonious killing of a child "born alive" as murder, even if the child received the fatal wound in the womb.

These authorities were followed by the English courts in permitting prosecutions of the killings of children born alive as murder. Rex v Senior, 1 Moody CC 346 (1832); Reg. v Trilloe, 174 Eng. Rep. 674 (1842); Reg. v West, 2 C & K 784 (1848).

Most critically, in the English law, a child did not have to be viable to be born alive. In 1848, the leading case of Regina v West, 2 C & K 784, was decided. The indictment for murder alleged that the defendant had inserted a "certain pin" "upward into the womb " of a pregnant woman for the purpose of producing the abortion of a "quick" child; and that this resulted in the child being "prematurely born and brought forth alive from and out of the womb." Id., 784-85. The child died shortly thereafter. A "medical witness" had testified that:

"(I)t was a healthy child; but that, being born at that period of gestation, it was impossible that it could live any considerable length of time separated from the womb of the mother. It was incapable

right of "privacy" announced in Roe v Wade includes the right to kill members of these groups, as well as the unborn. If the burden were suddenly thrust on these groups, as it was thrust on the unborn, to prove that they are persons whose lives are protected by the Fourteenth Amendment, what factual, non-argumentative evidence could they find to estab-

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of maintaining a separate and independent existence." Id., at 786.

The judge, relying on Coke and Blackstone, instructed the jury:

"The prisoner is charged with murder; and the means stated are, that the prisoner caused the premature delivery of the witness, Hensen, by using some instrument for the purpose of procuring abortion; and that the child so prematurely born was, in consequence of its premature birth, so weak that it died. .... I am of opinion(and I direct you in point of law), that if a person intending to procure abortion does an act which causes a child to be born so much earlier than the natural time, that it is born in a state much less capable of living, and afterwards dies in consequence of its exposure to the external world, the person who by her misconduct so brings the child into the world, and puts it thereby in a situation in which it cannot live, is guilty of murder." Id., at 788.

The case of Regina v West, supra, was presented by the leading English writers as the correct statement of the law of murder. See, e.g., 1 J.F. Archbold, A Complete Treatise on Criminal Procedure, Pleading and Evidence 783 (Waterman Am. ed. 7th ed. 1860); 1 W.O. Russell, A Treatise on Crimes and Misdemeanors 671-672 (4th ed. 1865); A.S. Taylor, A

lish their right to life?

As the case of the unborn shows, it would do no good to object that no one ever heard of such a constitutional right to kill, or to object that such killings had thereto been defined as criminal. And the Fourteenth Amendment merely states that it pro-

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Manual of Medical Jurisprudence 516(Penrose Am. ed. 6th ed. 1866). Consequently, the abortion of a quick but unviable child that resulted in the child being born alive so prematurely that its death was caused by its inability to survive outside the womb, was murder.

3. The American Law Of Murder in 1868.

The English common law of murder of children born alive is significant since American courts used the English common law to construe their murder statutes. Clarke v State, 117 Ala. 1(1898); Hamilton v United States, 26 App. D.C. 382(1905).

American courts cited Coke, Hawkins, Blackstone, and the English court decisions, as authoritative definitions on the law of homicide of children born alive. See, e.g., Clarke v. State, 117 Ala. 1(1898); State v Winthrop, 43 Iowa 519(1876). By 1868, leading American legal authorities had specifically cited Regina v West, supra, as the correct law of murder of a child born alive. (As already noted, that case held that if a criminal abortion resulted in the premature delivery of a quick but unviable child that died after delivery as a consequence of its being so prematurely delivered that it could not survive outside the womb, it was murder.) See, e.g., F. Wharton, A Treatise on the Law of Homicide in the United States 96-97(1855). By 1868, this appears to be the uncontradicted view.

tects life of "any person." So, as with the unborn, the Amendment does not expressly refer to the insane, or invalids, or Jews, or Catholics; and its legislative history does not appear to specifically refer to any of these groups. As with the unborn, the murder laws do not expressly refer to the insane,

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Consequently, the evidence shows that the life of a quick but unviable child born alive was protected by the murder laws in 1868.

4. The Law Of Murder In 1868 And The Fourteenth Amendment

Since the evidence shows that the life of a quick but unviable child was protected by the murder laws in 1868, the evidence likewise establishes that the child so born alive is a person within the language and meaning of the Fourteenth Amendment.

By seizing upon viability, Roe v Wade permits the killings of quick but unviable children born alive. The Supreme Court presumed to decree the killings of these children to be a constitutional right without any examination whatever to see if these children were persons within the language and meaning of the Fourteenth Amendment. It is a naked decree without any investigation into the law of murder of children born alive.

This raises the question,- Does the Supreme Court have the Hitler-like power to decree murder to be a constitutional right? If invalids were protected by the murder laws in 1868, can the Supreme Court, without evidence or investigation, decree a constitutional right to kill invalids? If Jews were protected by the murder laws in 1868, can the Supreme Court decree, without evidence or investigation, a constitutional

or invalids, or Jews, or Catholics; and their legislative histories, to the extent they have any, do not appear to specifically refer to any of these groups. The principle in the Declaration of Independence, that all people are "created" equal and endowed with an unalienable right to "life," having been

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right to kill Jews? If newspaper editors were protected by the murder laws in 1868, can the Supreme Court, without evidence or investigation, decree a constitutional right to kill newspaper editors?

No doubt the Supreme Court bears the burden of proving, by evidence so conclusive that it will not admit of a rational doubt, that it possesses the power to decree murder to be a constitutional right.

5. The Hysterotomy Abortion Under Roe v Wade

A common way to perform abortions under Roe v Wade is by hysterotomy. See, Commonwealth v. Edelin, 359 NE 2d 4(Mass. 1976). A hysterotomy is essentially a Caesarean, in which a live but unviable child is removed from the womb and left to die. 1 Hearings Before the Subcommittee On Civil And Constitutional Rights Of the Committee of the Judiciary, House of Representatives On Proposed Constitutional Amendments on Abortion 397 (94th Cong., 2nd Sess. 1976).

As established by medical testimony during the 1976 House Abortion Hearings, "With few exceptions, babies aborted by this method will all move, will all breathe, and some will cry .... Almost all were born alive." Id., at 397.

Consequently, by definition, in 1868, these hysterotomy abortions could have been prosecuted as murder.

sneered out of court in the unborn's case, now provides no assurance for anyone. So what factual, non-argumentative evidence is there for members of these groups to protect themselves from extermination?

The case presented herein for the unborn,

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6. Roe v Wade and Mistake of Law

The Supreme Court itself has recognized that constitutional provisions against ex post facto laws do not apply to judicial decisions that are a mistake of law. Ross v Oregon, 227 US 150(1913). Consequently, if Roe v Wade is a mistake of law, then mass murder is being perpetrated in America. The Roe v Wade hysterotomy killings, by definition under the common law, and thus constitutional law, violate the positive criminal murder statutes throughout the United States.

The killings of children born alive have been prosecuted as murder in the first degree, Comm. v Harmon, 4 Barr. 269 (Pa. 1846)(child thrown in creek); or murder in the second degree, Clarke v State, 117 Ala. 1 (1898)(wife beaten, child die from injuries); or manslaughter, People v Chavez, 77 Cal. App. 2d 621(1947)(child neglected),- according to the facts of the particular case, as in any other homicide.

In connection with these judicial killings, it is relevant to note that the Supreme Court decreed murder to be a constitutional right without any examination whatever of the law of murder of children born alive. And as Abraham Lincoln noted, "(I)t is an established maxim in morals that he who makes an assertion without knowing whether it is true or false, is guilty of falsehood; and the accidental truth of the assertion, does not justify or excuse him." 1 The Collected Works of Abraham Lincoln 384 (Basler ed. 1953). Since Lincoln's day, this "maxim in morals"

supra note 1, is thus the case for everyone else. The common law is the dictionary; it has traditionally been used to define the terms of the homicide statutes. It is this same body of factual evidence upon which all groups must ultimately rely to establish

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has also been a textbook definition of perjury. See, 3 Wharton's Criminal Law and Procedure, § 1308, p. 673 (12th ed. 1957).

Consequently, rational people are entitled to believe, and a jury may be permitted to find, that the process by which the Supreme Court decreed murder to be a constitutional right is perjury or criminal fraud. It seems reasonable that such judicial killings, after such prolonged deliberation and adherence, could be prosecuted as murder in the first degree. Many states still punish mass murder in the first degree with the death sentence.

It may be that the judges responsible for the judicial killings did not believe that they were breaking the law. But, as Justice Oliver Wendell Holmes once wrote, "Ignorance of the law is no excuse for breaking it." "It is no doubt true that there are many cases in which the criminal could not have known that he was breaking the law, but ... the lawmaker has determined to make men know and obey." Holmes, The Common Law 41 (Howe ed. paperback 1963).

It now full well appears that the Justices of the Supreme Court of the United States have presumed to decree murder to be a constitutional right, without any evidence or examination whatsoever, with the death penalty the possible consequence of their decision being a mistake of law.

It now appears that, unless the Supreme Court can prove by evidence, beyond a doubt based on reason, that it has the Hitler-like power to decree mass

their right to life. The evidence, supra n.1, conclusively proves that the Supreme Court has Hitler-like, that is, by naked decree without any investigation of the law of murder, asserted to legalize mass murder. Roe v Wade is a mistake of law, that is, no law at all. All the countless thousands of

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murder to be a constitutional right, then Roe v Wade is just such a mistake of law.

CONCLUSION

Is government of laws founded upon evidence, or the mere naked decrees of men holding office for life?

The evidence proffered herein would appear sufficient to permit reasonable people to conclude beyond a reasonable doubt that the Supreme Court of the United States has committed mass murder in the first degree. The evidence would appear sufficient for reasonable people to conclude that, upon a scale never seen before in the peacetime history of the world, "The dagger of the assassin was concealed beneath the robe of the jurist." The Justice Case, 3 Trials of War Criminals Before the Nuernberg Military Tribunals 985 (GPO 1951).

If the United States were being ruled over by a Tribunal of Murderers, holding office for life, nakedly decreeing mass murder to be a constitutional right, in open defiance of the evidence, and presuming to be blindly obeyed by all courts, executives, legislatures, and people whatever without question, regardless of the evidence, then surely it would be the most astounding event in the legal history of the human race.

born alive Roe v Wade killings since 1973 can be prosecuted as murder. Anyone who takes part in this national scheme of on-going killings in any intentional manner whatever, even by mere words of encouragement in Court, can be prosecuted for complicity in mass murder just as if Roe v Wade had never been decided. The Supreme Court is not above the law of murder. Roe v Wade is no law at all, and ought to be expressly overruled to reflect the true state of the law.

The evidence shows that the United States is being ruled over by a tribunal of murderers which has Hitler-like asserted to legalize mass murder, and maintains the killings year after year by willfully refusing to allow counsel to represent the victims being killed and defend the victims right to life under the U.S. Constitution. But even the Supreme Court is not above the law of murder, and many states still punish mass murder with the death penalty.

THE VICTIMS BEING KILLED BY ROE v WADE ARE CONSTITUTIONALLY ENTITLED TO BE ESPECIALLY REPRESENTED BY RETAINED COUNSEL TO DEFEND THEIR RIGHT TO LIFE UNDER THE CONSTITUTION.

The victims being killed have a constitutional right to be especially represented by retained(no cost to taxpayers) counsel to defend their right to life under the U.S. Constitution. 2/

Alan Ernest
Counsel

2./ Goldberg v Kelly, 397 U.S. 254, 268-270(1970). In Re Gault, 387 U.S. 1(1967); Morrissey v Brewer, 408 U.S. 471 (1972); Gagnon v Scarpelli, 411 U.S. 778(1973); Viteck v Jones, 63 L Ed 2d 552(1980); Gideon v Wainwright, 372 U.S. 335 (1963); United States v Altstoetter(The Justice Case), 3 Trials of War Criminals Before the Nuernberg Military Tribunals 1046 (1951).

The right to retained counsel under these circumstances is certain and indisputable. It can not be pretended that it is any longer the government of the United States, or any government of Constitution and laws, wherein judges assert to legalize mass murder, and then maintain the killings year after year by willfully refusing to allow counsel to represent the victims being killed and defend their right to life under the Constitution.

The amicus curiae brief filed herein by the Legal Defense Fund For Unborn Children is incorporated by reference in its entirety.

A-1

The photograph, supra A-1, shows a second stage abortion by prostaglandin. Such abortions not uncommonly result in the child being born alive.[1/] This Court could be prosecuted for murder for such a killing. There have been many thousands of such killings under Roe v Wade. And witnesses live to tell.

And if the child were killed in the womb and born dead, then this Court could be prosecuted for criminal extermination in violation of the Fifth and Fourteenth Amendments and 18 U.S.C. 242.[2/]

As the Court studies the face of this victim of Roe v Wade, let it contemplate that a government of laws shall be restored, and the law shall call the killers to account.

1./ Floyd v Anders, 440 F. Supp. 535,538(1977). The common second stage abortion techniques-hysterotomy, prostaglandin, and even salt poisoning-can result in the child being born alive. Jefferies & Edmonds, Abortion: The Dreaded Complication, The Philadelphia Inquirer, August 2, 1981.

2./ The amicus curiae brief by the Legal Defense Fund For Unborn Children shows that the unborn are persons whose lives are protected by the Fifth and Fourteenth Amendments of the U.S. Constitution.Thus their lives are also protected by 18 U.S.C. 242.

Supplemental Brief

2

No. 81-185

RECEIVED
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In The
SUPREME COURT OF THE UNITED STATES
October Term 1981

CHRIS SIMOPOULOS, APPELLANT

vs.

COMMONWEALTH OF VIRGINIA, APPELLEE

APPEAL FROM THE SUPREME COURT OF VIRGINIA

MOTION FOR LEAVE FOR AMICUS CURIAE TO PARTICIPATE IN ORAL ARGUMENT

ALAN ERNEST
P.O. Box 2471
Washington, D.C. 20013
(703) 437-1178

Counsel for Amicus Curiae

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Lafave and Scott, Criminal Law (1972).....5

McCormick, Evidence (2d ed. 1972).....5

Model Penal Code, Tentative Draft #4.....5

Perkins, Criminal Law (2d ed 1969).....5

Plato (Jowett transl. Classics Club 1942).....5

Ramsbotham, Principles and Practice of Obstetric Medicine (4th ed. 1856).....3

Velpeau, Complete Treatise on Midwifery (4th Am. ed. 1852).....3

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MOTION FOR LEAVE FOR AMICUS CURIAE TO PARTICIPATE IN ORAL ARGUMENT

The Court is moved to allow the amicus curiae, THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN, to participate in oral argument for the purpose of presenting the evidence which shows that Roe v Wade, 410 U.S. 113, is a mistake of law, and must be expressly overruled. This would dispose of all issues raised by the parties.

Only the amicus curiae has presented this issue; the parties did not do it. The grounds for determining that Roe v Wade is a mistake of law are presented in part I, infra.

I.

THE AMICUS CURIAE MOVES THE COURT TO ALLOW ORAL ARGUMENT THAT ROE v. WADE IS A MISTAKE OF LAW. THE PARTIES HAVE NOT DONE THIS. THE TWO GROUNDS PRESENTED ARE SO FUNDAMENTAL THAT IF THE COURT AGAIN AFFIRMS ROE v WADE, BUT AGAIN REFUSES TO HEAR THE TWO GROUNDS, THEN IT CAN NOT BE PRETENDED THAT IT IS ANY LONGER THE GOVERNMENT OF THE UNITED STATES, OR ANY GOVERNMENT OF CONSTITUTION AND LAWS.

A. Ground One

ROE v WADE IS A MISTAKE OF LAW BECAUSE THE COURT ASSERTED, WITHOUT ANY INVESTIGATION OF THE LAW OF MURDER, TO LEGALIZE KILLINGS WHICH HAD BEEN DEFINED AS MURDER SINCE LONG BEFORE THE ADOPTION OF THE FOURTEENTH AMENDMENT.

Without any examination of the law of murder, this Court in Roe v Wade asserted to legalize killings which had been defined as murder since long before the adoption of the Fourteenth Amendment.[1/] The Court has Hitler-like asserted to legalize murder. This is mere historical fact.

B. Ground Two

ROE v WADE IS A MISTAKE OF LAW SINCE IT IS BASED ON FALSE EVIDENCE, AND A FATAL REVERSAL OF THE BURDENS OF PROOF, AND THE UNBORN VICTIMS ARE BEING EXTERMINATED IN VIOLATION OF THE CONSTITUTION AND LAWS OF THE UNITED STATES.

The Supreme Court's conclusion in Roe v Wade, 410 U.S. at 158, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," is based on a fatal reversal of the burdens of proof and persuasion, and indispensable parts of the Court's supporting evidence are fabricated and false.[2/] The evidence

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1./ This evidence was incorporated in the Amicus Brief.

2./ This evidence was incorporated in the Amicus Brief and is summarized below for convenience. This evidence conclusively proves that the unborn are persons whose lives are protected by the Fourteenth Amendment, as follows:

A.

Even the Supreme Court admitted in Roe v Wade, 410 U.S. at 156-157, that if the

establishes, beyond the legal power of any judge of the United States to deny, that the unborn are persons within the language and meaning, the very express words as well as the spirit, of the

unborn child "is a person within the language and meaning of the Fourteenth Amendment," then the case for a constitutional right to kill the unborn, as claimed in Roe v Wade, "of course, collapses, for the fetus' right to life would then be guaranteed specifically by the Amendment."

B.

The terms of the Fourteenth Amendment ("nor shall any state deprive any person of life ... without due process of law")(emphasis added) are "universal in their application." Yick Wo v. Hopkins, 118 U.S. 356, 369 (1886). The words "any person" are universal and admit of no exceptions whatever. Thus, on their face, the words "any person" include the unborn, as everyone else.

C.

The holdings of Chief Justice John Marshall show that the Supreme Court had no lawful power to construe an exception to express, universal terms (such as "any person") unless the court can show that "the absurdity and injustice of applying the provision to the case, would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application." Sturges v Crowninshield, 4 Wheat. 122, 202-3. And the Court must further prove that "had this particular case been suggested" to the framers, "the language would have been so varied as to exclude it." Dartmouth College v Woodward, 4 Wheat. 518, 644-5. Chief Justice Marshall founded the universality of this court's own jusisdicton on these very rules. Cohen v Virginia, 6 Wheat. 264, 378-380. Thus, the Court bore an extraordinary burden to prove that if the case of the unborn had been brought to the attention of the framers of the Fourteenth Amendment, they would have varied the language to exclude the unborn and the Amendment would have been changed to effectively read that "Nor shall any state deprive any person, except unborn persons, of life ... without due process of law.

D.

The Supreme Court presented false evidence in Roe v Wade to support its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. And, but for the false evidence, there is not even a credible foundation, much less a compelling one, for creating an exception to the universal terms "any person" and denying the protection of the Amendment for the lives of the unborn.

At the time the Fourteenth Amendment was adopted in 1868, most states had already enacted positive statutes which made abortion a crime unless it were necessary to save the life of the mother. Within a few years, these criminal abortion statutes were virtually universal.

Consequently, any theory of a constitutional right to kill the unborn, as claimed in Roe v Wade, faced an impossible contradiction: How is it possible that the people who framed and adopted the Fourteenth Amendment had enacted positive criminal statutes to protect unborn life, but, at the same time, without a single word of explanation, intended to imply an exception to the express, universal terms "any person," and to imply a constitutional right to kill the unborn?

To resolve that fatal contradiction, the Court asserted the hypothesis that when the criminal abortion statutes were first enacted, the laws were not intended to protect unborn life, but rather were only intended to protect the mother. The hypothesis was falsely fabricated and used as follows.

1.

The Supreme Court first asserted, "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman." Roe v Wade, 410 U.S. at 148. This is asserted as fact.

The only authority cited by the Supreme Court to prove this assertion of fact was a 20th century medical history book, Haagensen and Lloyd, A Hundred Years of Medicine 19 (1943), cited in Roe v Wade, supra, at 148 n.43. But this book merely described the hazards of major surgery in general prior to Lister's discovery of antiseptics. The reference did not even mention abortion.

However, the 19th century authorities throughout the Western world prove the

of the Fourteenth Amendment, and thus the lives of the unborn are protected by the Amendment.

Court's assertion of fact to be false. These obstetric authorities, based upon their own experience in performing abortions, and from hundreds of cases reported from around the world, declared that the abortion operation, the operation of artifically evacuating the fetus from the womb, was "perfectly safe" to the mother. 2 T. Denman, M.D., An Introduction to the Practice of Midwifery 96 (1802). Or, "experience has proved that the dangers of the operation are reduced to a small matter." A.L.M. Velpeau, A Complete Treatise on Midwifery 530 (4th Am. ed. 1852). Or, "to the mother there is very little danger." H.L. Hodge, M.D., The Principle and Practice of Obstetrics 293 (1864). In short, the 19th century obstetric authorities prove the Supreme Court's assertion of fact to be false.

The Supreme Court never identified the "hazardous" abortion "procedure" to which it was referring. Actually the 19th Century physicians used the ancient method: "the membranes of the ovum are punctured," which permitted "the discharge of the waters," which induced the "action of the uterus" to "come on," which resulted in the expulsion of the fetus from the womb. 2 Denman, supra, 99. One 19th Century physician traced this operation back almost 2000 years. F. Ramsbotham, M.D., The Principles and Practice of Obstetric Medicine 724 (4th ed. 1856).

Consequently, the 19th Century physicians were using an ancient abortion procedure which they described as not hazardous to the mother. The Supreme Court did not examine even one single 19th Century medical textbook. And those medical texts prove its assertion of fact, "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman," is false.

3.

The Supreme Court next asserted, "Abortion mortality was high." Roe v Wade, supra, at 149. This is also asserted as fact. The Supreme Court made this assertion without any authority to support it. It is likewise false. The 19th Century obstetric authorities expressly asserted that the abortion operation was not deemed to be hazardous to the mother. Consequently, the Court's assertion of fact, "Abortion mortality was high," is false.

4.

Upon these two false assertions of fact, the Supreme Court falsely infers that "a State's real concern in enacting a criminal abortion law was to protect the pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy." Roe v Wade, supra, at 149. Thus a false inference is drawn from false assertions of fact.

5.

From the false inference that the criminal abortion laws were not intended to protect the lives of the unborn, the Court further falsely inferred that the framers of the Fourteenth Amendment did not intend it to protect the lives of the unborn, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. This false conclusion is drawn from a false inference which is drawn from false facts.

6.

The Supreme Court bore the extraordinary burden of demonstrating that the absurdity and injustice of including the unborn within the universal terms "any person" would be "so monstrous, that all mankind would, without hesitiation, unite in rejecting the application." Sturges v Crowninshield, supra. And the Court bore the extraordinary burden of proving to a demonstration that if the case of the unborn had been presented to the Framers of the Fourteenth Amendment, "the language would have been so varied as to exclude it." Dartmouth College v. Woodward, supra.

But, the Court did not cite even one single 19th Century authority which expressly agreed with its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," much less one that expressly agreed that there was a constitutional right to kill the unborn as asserted in Roe v Wade. And the Court's assertion that the abortion laws were not intended to protect the lives of the unborn is shown to rest on false evidence. The authorities in law, medicine, and medical jurisprudence leave no doubt that these abortion laws were originally intended to protect the lives of the unborn. These statutes show that the framers and adopters not only intended the universal terms "any person" to include the unborn, but that they had enacted criminal laws to protect them in fact.

E.

Not only are indispensable parts of the Court's evidence false, but the Court

II.

THE U.S. SUPREME COURT IS WILLFULLY USING UNCONSTITUTIONAL PROCEDURES TO MAINTAIN THE ROE v WADE KILLINGS

The Supreme Court has decided many abortion cases on the merits, but the Court willfully (1) refused to allow counsel to especially represent the victims being killed, and(2) refused to allow the evidence in Roe v Wade, which it used to condemn the victims to death, to be cross examined, and (3) refused to allow new evidence to be presented on behalf of the victims being killed to establish their right to life under the U.S. Constitution.[3/] Under the Court's own rulings these procedures are unconstitutional[4/] and criminal.[5/]

III.

THE U.S. SUPREME COURT HAS CONFESSED IN COURT THAT IT IS GUILTY OF CRIMINAL EXTERMINATION, INCLUDING MASS MURDER, AND THIS IS THE LEGAL EQUIVALENT OF THE EXPRESS OVERRULING OF ROE v WADE.

For the 53rd time, the Supreme Court is accused of mass murder. For the 77th time, the Supreme Court is accused of exterminating millions of victims in violation of the Fourteenth Amendment and 18 U.S.C. 242. But the Court has not denied the charges and proved

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also fatally reversed the burdens of proof and persuasion described by Chief Justice Marshall, supra. The Court first decreed a constitutional right to kill the unborn. Roe v Wade, supra, at 153. Then, incredibly, after that death sentence was imposed, the Court subsequently examined the question of the inclusion of the unborn within the terms "any person." Roe v Wade, supra, at 158-9. Thus, in accordance with the compelling interest test, once the Court decreed a constitutional right to kill the unborn, the burden was shifted to the unborn to demonstrate the compelling justification of the criminal abortion statutes; that is, the burden was on the unborn to affirmatively prove that they were persons within the terms "any person " in the Amendment. And the Court placed the burden on the unborn to prove with "assurance" (that is, to make certain, and put beyond doubt) that they were persons within the Amendment, or the unborn would be excluded. This reversal of the burdens was not only fatal, but monstrous. Could the Court first decree a right to kill Jews, then place the burden on the Jews to prove with "assurance" that they were persons protected by the Constitution, and then upon false evidence or trifling objections, permit all Jews to be exterminated?

Rather the most difficult evidentiary burden in constitutional law was on the Court to prove with "assurance" that the unborn were not included within the terms "any person," or the unborn would be included. And the case for the unborn is far stronger than for many other groups, such as "strangers and aliens" and "corporations" which were included within the terms "any person" without the need of any independent corroborating evidence since the terms "any person" are "universal in their application." Yick Wo v Hopkins, supra. The terms "any person" include the unborn on their face; and the framers and adopters had enacted criminal statutes to protect the lives of the unborn in fact.

F.

The Supreme Court has violated the very letter of the Constitution, as well as its spirit, and condemned to death those victims whom the Constitution endeavors to preserve.

3./ Cases presented in Amicus Brief

4./ Cases presented in Amicus Brief

5./ Any judge who, under color of law, willfully deprives anyone of constitutional rights can be criminally prosecuted. Imbler v Pachtman, 424 U.S. 40%.

Since the unborn are persons within the terms "any person," their lives are, by statutory definition, also protected by 18 U.S.C. § 242.

them false. Under the Court's own rulings, its silence in the face of accusation, while looking at photos of the killed victims, [6] can be taken as a confession that the charges are true.[7] Such judicial conduct is the admission that Roe v Wade is a mistake of law as certainly as the express overruling of Roe v Wade. And this tacit overruling has the same legal consequences as an express overruling.[8]

IV.
CONCLUSION

The court is moved to allow Amicus to appear at oral argument to present the evidence which proves that Roe v Wade is a mistake of law and must be expressly overruled.

Alan Ernest

Alan Ernest, Counsel for Amicus

6./ A photograph of the type killings complained about is included herein as Exhibit 1, infra A-1.

7./ Under "the tacit confession rule," McCormick on Evidence §§ 161, 171 (1972), failure to deny a charge is equivalent to a confession that the charge is true. 4 Wigmore, Evidence §§1071-1072(Chadborn rev. 1972). "Underlying the rule is the assumption that human nature prompts an innocent man to deny false accusations and consequently a failure to deny a particular accusation tends to prove belief in the truth of the accusation." McCormick, supra, §161. And this Court has consistently recognized that ... silence in the face of accusation is a relevant fact. .... Silence is often evidence of the most persuasive character. Baxter v. Palmigiano, 425 U.S. 308, 319 (1976). And the rule is ancient. As Socrates cross-examined at his trial over 2000 years ago, "you are silent and have nothing to say. But is this not rather disgraceful, and a very considerable proof of what I was saying." Apology in Plato 41, 45 (Jowett transl. 1942). And concerning the Court's silence in the face of accusation year after year while the victims are being killed- "Silence gains more probative weight where it persists in the face of accusation, since it is assumed in such circumstances that the accused would be more likely than not to dispute an untrue accusation." United States v Hale, 422 U.S. at 176.

8./ The Supreme Court asserted to legalize killings which violated positive criminal statutes, including murder statutes. If Roe v Wade were a mistake of law, then all the killings since 1973 can be criminally prosecuted. The ex post facto provisions of the U.S. Constitution do not apply to judicial decisions which are a mistake of law. Ross v Oregon, 227 U.S. 150 (1913). The general rule is that mistake of law is no excuse for breaking the law. Perkins, Criminal Law 90 (2d ed. 1969). The narrow exception of reasonable reliance on a court opinion thereafter determined to be a mistake of law does not apply to homicide cases. Model Penal Code, Tentative Draft No. 4, Comments §2.04, at 138. In any event, "after a warning," such as given herein, a defendant can not claim that his reliance was reasonable. Id., at 138. And one can be criminally implicated in homicide by mere words of encouragement while the victims are being killed in violation of positive criminal statutes. Lafave and Scott, Criminal Law §§ 61, 64(1972). One must literally hazard life and liberty to argue in favor of the Roe v Wade killings in violation of criminal statutes. Blind faith in "the supreme judge" is no defense to criminal prosecution for complicity in murder. United States v. Altstoetter ("The Justice Case"), 3 Trials of War Criminals before the Nuremberg Military Tribunals.

A I

Amicus Brief

6

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Nos. 81-185, 81-746 and 81-1172, 81-1255 and 81-1623

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE ON BEHALF OF NATIONAL ORGANIZATION FOR WOMEN; NATIONAL ABORTION RIGHTS ACTION LEAGUE; NORTHWEST WOMEN'S LAW CENTER; WOMEN AND HEALTH ROUNDTABLE AND WOMEN'S LAW PROJECT

PHYLLIS N. SEGAL
JUDITH I. AVNER
(Counsel of Record)
ANNE E. SIMON
NOW Legal Defense and Education Fund
132 West 43 Street
New York, New York 10036

JEMERA RONE
919 Third Avenue
New York, New York 10022

Attorneys for Amici Curiae

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,

—v.—

CITY OF AKRON, et al.,
Defendants-Respondents.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Petitioners,

—v.—

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Petitioners,

—v.—

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Respondents.

In the
SUPREME COURT OF THE UNITED STATES
October Term, 1982

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Chris Simopoulos, M.D., FACOG,
Appellant,
v.
Commonwealth of Virginia,
Appellee.

Nos. 81-746 and 81-1172
City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive
Health, Inc., et. al.,
Plaintiffs-Respondents.

Akron Center for Reproductive
Health, Inc., et al.,
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v.
City of Akron, et al.,
Defendants-Respondents.

Nos. 81-1225 and 81-1623

Planned Parenthood Association of
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Plaintiffs-Petitioners,
v.
John L. Ashcroft, Attorney General
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Defendants-Respondents.

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Kansas City, Missouri, Inc., et al.,
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ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SIXTH AND EIGHTH CIRCUITS

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF NATIONAL ORGANIZATION FOR WOMEN, NATIONAL ABORTION RIGHTS ACTION LEAGUE, NORTHWEST WOMEN'S LAW CENTER, WOMEN AND HEALTH ROUNDTABLE, AND WOMEN'S LAW PROJECT

The National Organization for Women, National Abortion Rights Action League, Northwest Women's Law Center, Women and Health Roundtable and Women's Law Project respectfully move, pursuant to Rule 36.3 of this Court's Rules, for leave to file the attached brief amici curiae. Counsel for Appellant Chris Simopoulos, Petitioner City of Akron, Respondent Akron Center for Reproductive Health, Petitioner Ashcroft and Respondent Planned Parenthood Association of Kansas City have consented to the filing of this brief and their letters of consent

have been filed with the Clerk. The Commonwealth of Virginia has refused consent.

The NATIONAL ORGANIZATION FOR WOMEN is a national membership organization of 170,000 women and men in over 750 chapters throughout the country. NOW has as one of its priorities, the preservation of the right to reproductive freedom, including abortion. NOW believes that every woman has a fundamental constitutional right to decide whether to terminate her pregnancy by abortion. NOW submits that the restrictions challenged herein impermissibly impinge upon this constitutionally protected right.

The NATIONAL ABORTION RIGHTS ACTION LEAGUE is dedicated to keeping abortion legal, safe and available. It has more than 150,000 national members plus af-

filiates with their own membership drawn from the pro-choice majority throughout the country.

The NORTHWEST WOMEN'S LAW CENTER is a non-profit public interest law organization dedicated to securing equal rights for women through law. Located in Seattle, the Law Center conducts community and continuing legal education programs throughout the Northwest on women's legal rights; offers information and referral, and advice and counseling services; and provides legal representation or assistance in selected cases that will impart the laws and legal rights of large numbers of women.

The WOMEN AND HEALTH ROUNDTABLE, a project of the Federation of Organizations for Professional Women, is an association of organizations and indi-

viduals concerned with women's health issues and policy. Through a series of publications and forums during its five year history, the Roundtable has monitored public health policy and analyzed its implications for women. The Roundtable is concerned that policies such as those before this Court, would infringe on a woman's constitutionally protected right to choose to terminate her pregnancy.

The WOMEN's LAW PROJECT is a non-profit public interest law firm working since 1973 to challenge sex discrimination in the law and in legal and social institutions.

Amici are womens' rights organizations whose constituencies and interests are seriously affected by the decisions in these cases. At issue is the consti-

tutionality of governmentally created obstacles to the exercise of a woman's constitutionally protected right to decide whether to terminate a pregnancy. Amici request leave to file this brief because of the extraordinary importance of these cases to the lives of women and children. Amici believe that their brief will elaborate for the Court the grave impact on individuals of the government restrictions challenged herein.

Respectfully submitted,

Phyllis N. Segal
Judith I. Avner
(Counsel of Record)
Anne E. Simon

NOW Legal Defense
and Education Fund
132 West 43 Street
New York, N.Y. 10036

Jemera Rone
919 Third Avenue
New York, N.Y.

Attorneys for Amici Curiae

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Harris v. McRae, 448 U.S. 297 (1981)	10, 34, 40
Leigh v. Olson, 497 F. Supp. 1340 (D.N.D. 1980).	27, 29, 30, 55
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Women's Community Health Centers, Inc. v. Cohen, 477 F. Supp. 542 (D. Me. 1979).	18, 22, 51
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Women's Services, P.C. v. Thone, 483 F. Supp. 1022 (D. Neb. 1979), aff'd, 636 F.2d 206 (1980), judgment vacated and remanded, 452 U.S. 911 (1980) 59, 60

Wynn v. Scott, 449 F. Supp. 1302 (N.D. Ill. 1978) 27, 28

Statutes

Akron, OH., ORDINANCE No. 160 §1870.06B (3), (4), (5) (1978) 25, 26

Conn. Agencies Regs.§ 19-13-D54

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Ga. Code Ann.
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Hawaii Rev.
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(1970) 15

Idaho Code
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Abortion Law of 1975,
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Mass. Gen. Laws Ann.
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1974). 15

Mich. Admin. Code
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Mo. Ann. Stat.
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Mont.
Code Ann. § 94-5-618
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Nev. Rev. Stat.
442.250.2 (1981) . . . 15

N.J.
Admin. Code, tit. 13
§ 13, § 35-7.2 (1978). 15

N.Y. Pub. Health Law
§ 4164 (1974). 15

N.D. Cent.
Code ch. 14-02:1-04.2
(1981) 15

Okla. Stat. tit.
63 § 1-731.B (1978). . 15

Tenn. Code Ann. § 39-301(e)
(1981) 15

Utah Code Ann.
§ 76-7-302(2) (1974) . 15

Va.
Code § 18.2-73 (1975). 15

Wis.
Admin. Code, § Chap. Med.
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Legislative Materials	
122 CONG. R. H26784 (daily ed. August 10, 1976) (Statement of Rep. Hyde)	33
Other Authorities	
American College of Obstetricians and Gynecologists, *Manual of Standards for Obstetrician Gynecological Services*	44, 45
Allan Guttmacher Institute, *11 Million Teenagers* 23 (1976).	23
Cates, Grimes, "Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities," 58 *Obstetrics and Gynecology* 401 (1981).	45, 46

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Donovan, "Analysis: Courts Rejecting 'Maternal Health' Rationale for Hospitalization for all Mid-trimester Abortions", 9 Fam. Plan./ Population Rep. 91, 91 (Dec. 1980). 21, 32, 45

Henshaw, Forrest, Sullivan, Tietze, "Abortion Services in the United States, 1979 and 1980", 14 Fam. Plan. Persp. 5 (1982) 14

National Academy of Science Institute of Medicine, Legalized Abortion and Public Health 64 (1975) 35

Page

Pettiti and Cates, "Restricting Medicaid Funds for Abortions: Projections of Excess Mortality for Women of Childbearing Age", 67 Am. J. Pub. Health 860, 861 (1977) 35

Schulman, Kaiser, Randolph, "Outpatient Saline Abortion," 37 Obstetrics and Gynecology 521 (1971) 46

U.S. Department of Health, Education & Welfare, Center for Disease Control, Abortion Surveillance Annual Summary 1977 (1979). 35

In the
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October Term, 1982

No. 81-185

Chris Simopoulos, M.D., FACOG,
Appellant,
v.
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ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SIXTH AND EIGHTH CIRCUITS

BRIEF AMICI CURIAE OF THE NATIONAL ORGANIZATION FOR WOMEN, NATIONAL ABORTION RIGHTS ACTION LEAGUE, NORTHWEST WOMEN'S LAW CENTER, WOMEN AND HEALTH ROUNDTABLE AND WOMEN'S LAW PROJECT

INTEREST OF AMICI

The interest of amici appears in the foregoing motion.

INTRODUCTORY STATEMENT AND SUMMARY

These three cases involve attempts by state and local governments to restrict the opportunity of a woman to exercise her constitutionally protected decision to terminate her pregnancy. In Simopoulos v. Commonwealth of Virginia, No. 81-

185, the constitutionality of a Virginia statute that requires, inter alia, that all post-first trimester abortions be performed in hospitals is being challenged by a physician convicted of violating this law. He is appealing from the Virginia Supreme Court's affirmance of his conviction. 221 Va. 1059; 277 S.E.2d 194 (1981).[1] A Missouri statute similarly requiring that all abortions after the first trimester of a pregnancy be performed in hospitals is at issue in Ashcroft v. Planned Parenthood Association of Kansas City, Nos. 81-1225 and

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[1] Other issues raised by Dr. Simopoulos on appeal include whether the burden of proof imposed on him was improper and whether the prosecution failed to produce evidence necessary for conviction. These issues of due process and fairness in criminal proceedings, although important, are outside the specific interests of amici and are not addressed herein.

81-1623. The Eighth Circuit upheld the constitutionality of this provision, 655 F.2d 848 (8th Cir. 1981).[2]

City of Akron v. Akron Center for Reproductive Health, Nos. 81-746 and 81-1172, involves a challenge to the constitutionality of an Akron, Ohio ordinance that imposes an in-hospital requirement similar to those in the Virginia and Missouri laws. In addition, the Akron ordinance requires that a woman seeking an abortion be counseled by the attending physician; that she be

---

[2] Also presented for review are requirements that: minors obtain judicial authorization or parental consent for an abortion; a pathology report be submitted for every abortion; two physicians be present at all second trimester abortions. All but the first of these provisions were struck down by the Eighth Circuit. Although amici believe that all three of these provisions are invalid, they will not address them further herein.

told specified information before she consents to an abortion; and that she wait 24 hours after she consents before obtaining an abortion. The Sixth Circuit upheld the in-hospital requirement, but declared the counseling, consent and waiting period provisions unconstitutional, 651 F.2d 1198 (6th Cir. 1981).[3]

These statutory schemes all have the effect of burdening the procreative decisions of women. Amici believe that individuals have the constitutionally protected right to make such decisions

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[3] Other provisions of the Akron ordinance presented for review in this Court are requirements that all minors seeking abortions notify at least one parent and, if the minor is under 15 years of age, obtain the consent of at least one parent; and that the fetus be disposed of in a "humane" manner. These provisions were struck down by the Sixth Circuit. Amici believe that the Sixth Circuit's decision should be affirmed, but will not address these issues further herein.

free from government interference. In this brief, amici demonstrate the serious restrictive impact of certain of the legislative enactments at issue in these cases. Although some of these provisions were upheld and some struck down by the lower courts, amici argue that none of these restrictions can survive the strict judicial scrutiny mandated by this Court's precedents, and all should be invalidated.

ARGUMENT

I.

THE CHALLENGED REGULATIONS SERIOUSLY RESTRICT — AND IN SOME INSTANCES EFFECTIVELY ELIMINATE — THE FUNDAMENTAL RIGHT OF A WOMAN TO DECIDE WHETHER OR NOT TO TERMINATE HER PREGNANCY

The right of every individual to be free from governmental interference in the exercise of personal procreative decisions has long been recognized as a fundamental liberty protected by the United States Constitution. See, e.g., Carey v. Population Services International, 431 U.S. 678 (1977); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965). This Court has made clear that the constitutional right to privacy is "broad

enough to encompass a woman's decision whether or not to terminate her pregnancy." Roe v. Wade, 410 U.S. 113, 153 (1973). This right to reproductive choice "protects the woman from unduly burdensome interference with her freedom to decide to terminate her pregnancy." Maher v. Roe, 432 U.S. 464, 473-74 (1977).

Consistent with these principles, the Court has invalidated government imposed restrictions that run afoul of this constitutional standard. In Doe v. Bolton, 410 U.S. 179 (1973), for example, a state law requiring that all abortions be approved in advance by a hospital abortion committee was held unconstitutional because the limitation

was "unduly restrictive of the patient's rights and needs." 410 U.S. at 198. In Planned Parenthood v. Danforth, 428 U.S. 52 (1976), spousal and parental consent requirements could not pass constitutional muster because the state did not have the authority to "give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy." 428 U.S. at 74. See also Bellotti v. Baird, 443 U.S. 662 (1979).

The limitations on abortions imposed by the challenged restrictions in the trilogy of cases now before the Court similarly attempt to circumscribe a woman's behavior and significantly im-

pair the exercise of her fundamental right to decide whether to bear a child. These restrictions cannot be dismissed as "not burdensome or chilling." Planned Parenthood v. Danforth, 428 U.S. at 66, citing 392 F. Supp. at 1374. Nor can they be characterized as merely "state encouragement of . . . childbirth," Maher v. Roe, 432 U.S. at 475, or described as placing "no obstacles in the pregnant woman's path to an abortion." 432 U.S. at 474. See also Harris v. McRae, 448 U.S. 297 (1981). The statutory schemes enacted by Missouri, Virginia and Akron, Ohio forcefully inject government into a constitutionally protected decision-making process, riding roughshod over individuals' most

private decisions. They are aimed at coercing a woman not to terminate her pregnancy by placing obstacles directly in her path.

A. For Many Women, The Challenged Regulatory Schemes Effectively Eliminate The Right To Decide To Terminate A Pregnancy

Although benign sounding on its face, the requirement that a second trimester abortion be performed in a hospital effectively eliminates, for many women, the ability to exercise their fundamental right to reproductive choice. In Missouri, Virginia and Akron, Ohio, as in many areas of this country, there are few, if any, hospitals that perform second trimester abortions. Regulations requiring that all second trimester abortions be performed in hospitals

effectively eliminate the right to decide to terminate a pregnancy when there are no hospitals to provide such medical care.

For example, unrebutted testimony in the Akron case revealed that there were only two hospitals in Akron performing second trimester abortions, and during 1977, only nine second trimester abortions were performed in these two hospitals. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981). Many Akron women seeking second trimester abortions were referred to clinics in Cleveland, Ohio and in the state of Michigan. 651 F.2d at 1209. In Planned Parenthood Association v. Ashcroft, No. 79-4142, slip op.

at 10 (W.D. Mo. Oct. 2, 1981), aff'd, 664 F.2d 687 (8th Cir. 1981), the district court concluded that the effect of Missouri's in-hospital requirement was to render unavailable a common method of second trimester abortions in the state.[4] Similarly, testimony in Simopoulos v. Commonwealth of Virginia, 221 Va. 1059, 277 S.E.2d 194 (Sup. Ct. 1981), demonstrated that only two hospitals in Northern Virginia performed second trimester abortions.

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[4] On remand from the Eighth Circuit Court of Appeals in Planned Parenthood Ass'n v. Ashcroft, 655 F.2d 848 (8th Cir. 1981), the district court found that the in-hospital requirement in Missouri did in fact result in the performance of fewer second trimester abortions. Planned Parenthood Ass'n v. Ashcroft, No. 79-4142, slip op. at 9. The district court there had the benefit of reviewing expert testimony comparing the incidence of abortions in Missouri in two recent consecutive years, one without and one with the in-hospital requirement. Id. at 9 n.14 & 15 and text.

Nor is this picture unique to Missouri, Virginia or Akron, Ohio. In Louisiana, for example, no hospitals perform abortions after the first trimester. Margaret S. v. Edwards, 488 F. Supp. 181, 192 (E.D. La. 1980). A recent national survey indicated that less than one-third of all hospitals in the United States perform abortions after the first trimester.[5] Henshaw, Forrest, Sullivan, Tietze, "Abortion Services in the United States, 1979 and 1980," 14 FAM. PLAN. PERSP. Jan.-Feb. 1982, at 5 (1982) [hereinafter cited as "Henshaw"].

Where hospitals are unavailable to perform a second trimester abortion, a

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[5] Even where hospital facilities are available, the increased financial cost may put the abortion beyond the reach of many women. See discussion infra.

government imposed hospitalization requirement essentially acts as a governmental veto of a woman's decision to seek an abortion.[6] It operates as the kind of unauthorized, arbitrary governmental usurpation of a woman's constitutionally guaranteed right to decide to

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[6] Despite this dramatic unavailability of hospital facilities, twenty-one states have acted to require hospitalization for second trimester abortions. Conn. Agencies Regs.§ 19-13-D54 (1973); Ga. Code Ann. § 26-1202(b) (1973); Hawaii Rev. Stat. § 453-16(a)(2) (1970); Idaho Code Ann. 18-608.2 (1973); Abortion Law of 1975, Sec. 18-24, Ill. Rev. Stat. ch. 111 1/2, § 84 and Rules 12.6 and 12.61 (1977); Ind. Code 35.1-58.5(b)(2) (1974); Ky. Rev. Stat. § 311.760(2) (1974); La. Rev. Stat. Ann. § 1299.35.3 (West 1981); Mass. Gen. Laws Ann. ch. 112, § 12N(2)(West 1974); Mich. Admin. Code R.325.3851 (1979); Mo. Ann. Stat. § 188.025 (Vernon 1978); Mont. Code Ann. § 94-5-618 (1974); Nev. Rev. Stat. 442.250.2 (1981); N.J. Admin. Code, tit. 13 § 13, § 35-7.2 (1978); N.Y. Pub. Health Law § 4164 (1974); N.D. Cent. Code ch. 14-02:1-04.2 (1981); Okla. Stat. tit. 63 § 1-731.B (1978); Tenn. Code Ann. § 39-301(e) (1981); Utah Code Ann. § 76-7-302(2) (1974); Va. Code § 18.2-73 (1975); Wis. Admin. Code, § Chap. Med. 11.05 (1978).

terminate her pregnancy, consistently condemned by this Court. Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Bellotti v. Baird, 443 U.S. 622 (1979).

B. Where The Challenged Restrictions Do Not Totally Eliminate The Right of a Woman To Decide To Terminate a Pregnancy, They Unduly Burden Her Exercise of This Constitutionally Protected Right

Those challenged provisions that do not operate to totally eliminate the ability of a woman to decide to terminate her pregnancy nonetheless erect significant obstacles to the exercise of her right by imposing a mandatory waiting period, requiring attending physician counseling and establishing controlled consent procedures. This is also the consequence of the hospitaliza-

tion requirement in those areas where hospital facilities exist but are totally inadequate. These restrictions cause unnecessary delays in the performance of abortions; jeopardize the health of women who decide to terminate a pregnancy; and subtantially increase the financial costs of abortion, thereby limiting the ability of many women to undergo a safe, legal abortion procedure. They represent deliberate governmental intrusion into the constitutionally protected realm of personal decision-making.

1. The mandatory waiting period and the hospitalization requirements operate to cause unnecessary and health endangering delays in the performance of abortions.

Although advanced as a benevolent "cooling off" period, the mandatory

waiting period required by the Akron ordinance injects the government directly into the personal decision-making process reserved to the woman and her physician. The decision to seek an abortion is made after extensive consultation and consideration. See Women's Community Health Center, Inc. v. Cohen, 477 F. Supp. 542, 551 (D. Me. 1979). It is not made precipitously or irresponsibly as the language of the challenged legislation might have one think. Yet, once the decision has been reached, the mandatory waiting period temporarily forecloses the availability of an abortion. It is "direct state interference" with a woman's abortion decision. Maher v. Roe, 432 U.S. at 473-75, quoted in

Planned Parenthood League v. Bellotti, 641 F.2d 1006, 1014 (1st Cir. 1981).

Although the Akron restriction challenged herein explicitly imposes a 24-hour delay between the time a woman signs the consent form and undergoes the abortion, in reality the delay it causes will be far greater. The evidence in Akron showed that no city clinic performed abortions more than three times a week. Thus, a 24-hour waiting period may actually mean a minimum delay of two to four days. 651 F.2d at 1201. See also Planned Parenthood League v. Bellotti, 641 F.2d at 1014; Charles v. Carey, 627 F.2d 772, 785 (7th Cir. 1980). Especially for women who must travel to the abortion facility, this

extended delay can be a severe hardship. Such a scheme necessarily imposes

> burdens in terms of time, money, travel and work schedules; for many women, particularly the poor, the rural, and those with pressing obligations, these burdens will be substantial.

Planned Parenthood League v. Bellotti, 641 F.2d at 1015.

In addition, the second trimester hospitalization requirement, where not an insuperable barrier, similarly causes for many women a significant delay in obtaining medical care. As discussed at Point I, supra, hospital facilities are unavailable in many places, and where available, at best are inadequate. As a result, even where a facility can be found, travel time and the time it takes

to make appropriate arrangements (e.g., locating the hospital; scheduling hospital space availability; accommodating the woman's family and employment responsibilities) frequently result in delaying performance of the abortion. Donovan, "Analysis: Courts Rejecting 'Maternal Health' Rationale for Hospitalization for All Mid-Trimester Abortions," 9 FAM. PLAN./POPULATION REP. Dec. 1980, at 91 (1980) [hereinafter referred to as "Donovan"]. The adverse impact of travel necessitated by hospitalization requirements and the significant burden thereby imposed results in a significant relationship between a woman's distance from an abortion facility and the likelihood that she will obtain

an abortion. Margaret S. v. Edwards, 488 F. Supp. at 193-94 nn. 33 & 39.

As with any medical procedure, delay operates to increase the medical risk. The earlier in the pregnancy an abortion is performed, the lower the risk of complications or death. Courts have recognized that any risk to the woman presented by the abortion procedure increases the later the abortion is performed, affecting both her mental and physical health. See e.g., Planned Parenthood Association v. Ashcroft, 483 F. Supp. 679, 696 (W.D. Mo. 1980), aff'd in pertinent part, 655 F.2d at 866; Women's Community Health Center, Inc. v. Cohen, 477 F. Supp. at 551. Even a delay of two to seven days can pose a

major health risk to women undergoing abortions. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (Tr. I, 70, 82; III, 167-68).[7]

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[7] Expert testimony presented to the trial court in Akron indicated that generally, every week of delay beyond eight weeks' gestation increases the risk of morbidity by 20% and of mortality by 50%. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (Tr. IV, 156-57).

These serious consequences of delay must, however, be viewed in the context of the overall risks associated with pregnancy, childbirth, and abortion. All pregnancies pose health risks. These risks range from injury from falls occasioned by the unusual weight distribution of advancing pregnancy to death from hemorrhage, pulmonary embolism and toxemia, among other causes. McRae v. Califano, 491 F. Supp. 630, 668-71 (E.D.N.Y. 1980). The health problem is particularly acute for indigent pregnant teenagers, who suffer from higher maternal mortality rates and are more likely to suffer health complications from pregnancy. See McRae v. Califano, 491 F. Supp. at 680-81; Alan Guttmacher Institute, 11 Million Teenagers 23 (1976).

In fact, the risk of death from childbirth is significantly greater than the risk of death from abortion. The Court in Roe v. Wade, 410 U.S. 113 (1973), cited medical data as evidence that maternal mortality rates for early abortions "appear to

(Footnote continued)

Thus, by causing delays in the abortion procedure the challenged restrictions force women to jeopardize their health.

2. The controlled consent and attending physician counseling requirements interfere with medical judgments about a woman's care and have a direct, detrimental impact on a woman's health.

By intruding directly into the decision-making process at a critical time, the controlled consent and attending physician counseling requirements of the Akron ordinance are aimed at influ-

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be as low as or lower than the rates for normal childbirth" and concluded that in early abortion, "maternal mortality in abortion may be less than mortality in normal childbirth." Id. at 149, 163 (emphasis added). More recent statistics make clear that abortion is substantially safer than childbirth. McRae v. Califano, 491 F. Supp. at 65. Mortality in childbirth for white women in 1974 was 10 per 100,000 live births; mortality in abortion was 0.5. For "black and other" women, mortality in childbirth was 35.1 per 100,000 live births; in abortion, 2.4. Id.

encing the woman to continue her pregnancy. The government seeks to do this regardless of the woman's own decision-making choices, and heedless of the fact that the pregnancy may be life endangering or health-threatening.

The consent restriction challenged in Akron prescribes a script to be read, word-for-word, by the attending physician.[8] The provisions substitute the

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[8] In pertinent part, the ordinance requires the physician to tell a woman:

> (3) [t]hat the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external

(Footnote continued)

legislature's medical judgment for that of the attending physician. Not only does this straitjacket the physician's exercise of medical judgment, but its effect is to encumber the exercise of

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members;

(4) [t]hat her unborn child may be viable, and thus capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion;

(5) [t]hat abortion is a major surgical procedure, which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

AKRON, OH., ORDINANCE No. 160 § 1870.06B(3),(4),(5) (1978).

the woman's constitutionally protected right "by placing obstacles in the path of the doctor upon whom she was entitled to rely for advice ...." Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977), quoted in Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1207. See Planned Parenthood v. Danforth, 429 U.S. 52 (1976).

The challenged restriction requires the woman to be "informed" of "facts" that are incorrect,[9] prejudi-

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[9] See Planned Parenthood Ass'n v. Ashcroft, 655 F.2d at 868 (physicians' testimony that they do not believe there are long-term physical and psychological effects of abortion); Charles v. Carey, 627 F.2d at 784 (medical testimony characterizing possibility of "organic pain" to fetus as "medically meaningless, confusing, [and] medically unjustified"); Leigh v. Olson, 497 F. Supp. 1340, 1345 (D.N.D. 1980) (medical experts dispute validity of statement that abortion increases the risks of sterility, premature births, tubal pregnancies and still births in future pregnancies); Wynn v. Scott,

(Footnote continued)

cial[10] and irrelevant.[11] Rather than provide necessary information, the restrictions are calculated to inflict emotional distress, anxiety or physical

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449 F. Supp. 1302, 1317 (N.D. Ill. 1978) (studies have not supported statement that there is danger of subsequent sterility).

[10] See Planned Parenthood League v. Bellotti, 641 F.2d at 1021 (fetal descriptions and information on medical complications would cause many women emotional distress, anxiety, guilt or physical pain which might influence the decision, especially for those who were rape victims or who carried a potentially deformed fetus); Charles v. Carey, 627 F.2d at 784 (mandatory information was found to cause "cruel and harmful stress to . . . patients"). See also Planned Parenthood League v. Bellotti, 641 F.2d at 1022 (purpose of required information more moral than factual; "[t]he state may not add to its presentation of material facts such a moral overlay, an attempted imposition of ideas that is particularly objectionable in connection with the exercise of fundamental rights").

[11] See Planned Parenthood v. Danforth, 428 U.S. at 67 n.8 (consent requirement limited to "the giving of information . . . as to just what would be done and as to its consequences"); Planned Parenthood League v. Bellotti, 641 F.2d at 1021-23 (information must be material to medically relevant considerations).

trauma.[12] Planned Parenthood League v. Bellotti, 641 F.2d at 1021; Leigh v. Olson, 497 F. Supp. at 1345. Indeed, in addition to believing that some of the required information is detrimental to the best health interests of their patients, medical experts assert that the risks from abortion may be increased due to the woman's heightened tension and anxiety. Planned Parenthood Association v. Ashcroft, 655 F.2d at 868.

The Akron ordinance makes no exception, but inflicts the punitive "required reading" on all women, far surpassing any conceivable interest the

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[12] E.g., the majority of women would not want to hear fetal descriptions prior to an abortion and most doctors would not consider it good medical practice to provide them. Planned Parenthood League v. Bellotti, 641 F.2d at 1022.

state may have in assuring that the decision is knowingly made. See Charles v. Carey, 627 F.2d at 784.

Denominating the attending physician as the one who must provide the prescribed "information" similarly ignores the health needs of the woman. This requirement forces the physician to provide the information even though, in his or her professional judgment, a trained counselor would be much more effective in imparting certain information and obtaining consent. Women's Medical Center of Providence, Inc. v. Roberts, 530 F. Supp. 1136, 1147-48 (D.R.I. 1982); see Leigh v. Olson, 497 F. Supp. at 1346. It denies the physician this flexibility and may deprive

the woman of critically important support at an emotionally trying time.

3. The challenged restrictions increase the financial and emotional costs for the woman deciding to terminate her pregnancy.

The challenged restrictions further burden the exercise of the constitutional right to reproductive decision-making by unnecessarily increasing the financial costs of such medical care. The cost of having a second trimester abortion performed in a hospital on an inpatient basis is not insubstantial. It has been found to be at least twice the cost of the same procedure performed in an outpatient clinic. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d at 1209; Planned Parent-

hood Association v. Ashcroft, slip op. at 7 n.9,11 and text (W.D. Mo. Oct. 2, 1981); Donovan, 91.[13]

The travel frequently required to comply with hospitalization requirements and mandatory waiting periods imposes an additional significant economic burden on the abortion decision because of the expenses incurred for transportation, lodging and child care, as well as because of the loss of income due to the additional time required. These economic impediments to the decision to end a pregnancy by abortion are particularly critical in light of federal and state

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[13] On remand in Ashcroft, the district court found that the additional expense of having a second trimester abortion performed in a hospital as compared to a clinic, ranged from $150 to $1,650. Planned Parenthood Ass'n v. Ashcroft, slip op. at 7 n.9 and text (W.D. Mo. Oct. 2, 1981).

restrictions on the public funding of abortions.[14]

Although the Court has recognized that a woman's fundamental interest in personal privacy protects her choice of whether to continue or to terminate her pregnancy, Roe v. Wade, 410 U.S. 113 (1973), in reality, only those women able to pay the cost of their medical care can effectuate their constitutional choice between these two alternatives

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[14] Indeed the federal government has acted to deny funds for almost all abortions precisely because it wishes to subvert the reproductive choice of women seeking to terminate their pregnancies. For example, the chief sponsor of the funding restriction, Rep. Henry Hyde, declared his intention "to forbid the use of Federal funds to promote or encourage anyone to have an abortion," 122 CONG. R. H26784 (daily ed. August 10, 1976) (statement of Rep. Hyde). See also McRae v. Califano, 491 F. Supp. 630, 640-46 (E.D.N.Y. 1980).

free from state interference.[15] Where the physician cannot afford to work for no fee, and the woman cannot afford to pay, safe medical abortion is not a realistic alternative. See Singleton v. Wulff, 428 U.S. 106, 118-19 n.7 (1976). Governmental regulations designed to unnecessarily increase the cost of abortions, combined with virtual elimination of public funding, undoubtedly will have the intended effect upon many women: lacking feasible alternatives they will be forced to continue their unwanted pregnancies. And, for some, this will mean the unwilling continuation of a

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[15] As the Court recognized in Maher v. Roe, 432 U.S. 464, 474 (1977), by funding the childbirth alternative for the Medicaid-dependent woman and excluding the abortion alternative, the state deliberately influences the woman's reproductive choice. See Harris v. McRae, 448 U.S. 297 (1980).

life-endangering or health threatening pregnancy. The merger of increased regulation and decreased funding will have an additional, critical effect: emotionally distraught and unable to raise the money for a legal abortion, some women will turn in desperation to less costly and less safe illegal abortions.[16] The most recent statistics available show that in 1977, for the first time since 1972, reported deaths due to illegal abortions increased.[17]

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[16] U.S. Dep't of Health, Education and Welfare, Center for Disease Control, Abortion Surveillance Annual Summary 1977 12-14 (1979).

[17] Id. at 1. See Petitti and Cates, "Restricting Medicaid Funds for Abortions: Projections of Excess Mortality for Women of Childbearing Age," 67 Am. J. Pub. Health 860, 861 (1977).

Still other women will risk their lives by attempting one of the numerous dangerous methods of self-abortion.[18]

Thus, the increased emotional, health and financial costs resulting from the challenged restrictions impermissibly jeopardize and burden the health and well-being of women.

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[18] "Among the non-medical procedures used for inducing abortion," according to the National Academy of Sciences Institute of Medicine, "are eating or drinking quinine or other drugs, introduction of chemicals into the vagina, and mechanical methods such as inserting blunt or sharp instruments into the uterus through the vagina. The drugs quite often lead to poisoning or vomiting so intense that it results in dehydration and eventual death unless fluid replacement compensates the loss. Inserting chemicals or instruments in the vagina or uterus can lead to: (1) infection; (2) injury to the membranes of the vagina; (3) perforation of the uterus with the possibility of injury to other organs in the abdominal area; (4) bleeding due to retained fetal or placental tissue; and (5) air embolism." National Academy of Sciences Institute of Medicine, Legalized Abortion and Public Health 64 (1975).

II

THE CHALLENGED RESTRICTIONS DO NOT WITHSTAND CONSTITUTIONAL SCRUTINY

A. Strict Scrutiny Is Required Where, As Here, The Challenged Restrictions Burden A Woman's Exercise Of Her Fundamental Right To Terminate Her Pregnancy

This Court has repeatedly held that a statutory scheme which infringes upon a woman's fundamental right to decide to terminate her pregnancy by abortion can survive constitutional scrutiny only if justified by a compelling state interest that is narrowly drawn to express the legitimate state interests at stake.[19]

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[19] The strict scrutiny standard is called into play if two conditions exist. First, the obstacle to the exercise of the fundamental right must have been created by the government. Maher v. Roe, 432 U.S. 464 (1977). Second, the restriction must impinge upon the exercise of the fundamental right. Planned Parenthood v. Dan-

(Footnote continued)

Roe v. Wade, 410 U.S. at 155. The Court in Roe accepted the assertion by the State of Texas that there are legitimate state interests during the pregnancy in the health of the woman and in protection of potential fetal life.[20] Finding these interests to be separate and distinct, and conflicting with the woman's right to decide to terminate a pregnan-

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forth, 428 U.S. 52 (1976). Since both conditions are present, the obstacle created by the Missouri, Virginia and Akron, Ohio legislation can stand only if justified by a compelling state interest narrowly drawn. Roe v. Wade, 410 U.S. 113 (1973).

[20] This Court declined to define the point at which life begins. "When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." Roe v. Wade, 410 U.S. at 159. The Court rejected the attempt of Texas to define "life" as beginning at conception and thus to justify state interference throughout the pregnancy.

cy, the Court divided pregnancy into trimesters, defining the legitimate state interest, and therefore the parameters of state interference, at each juncture.

During the first trimester of pregnancy, neither the state's interest in the woman's health nor in potential fetal life can justify any state interference with the woman's right to decide. In the second trimester, state intrusion is permissible only if it promotes the state's legitimate interest in ensuring the woman's health. And in the third trimester, the state's interest in the potential life of the fetus is sufficient to justify significant intrusion, even a total proscription of

abortion, unless an abortion is necessary to preserve the life or health of the woman. See Roe v. Wade, 410 U.S. at 163-64; Harris v. McRae, 448 U.S. at 313. Thus, protecting the woman's health is the paramount state interest in the second and third trimesters of pregnancy. When measured against this interest, the challenged restrictions must fail, for they are nothing more than a thinly veiled attempt to limit the availability of abortions, in essence to accomplish through the back door what the Court forbade in Roe.

B. The Challenged Restrictions Cannot Withstand Strict Scrutiny And Are Invalid

1. The second trimester hospitalization requirement is not reasonably related to the state's legitimate interest in protecting the woman's health.

As discussed fully at Point I, supra, the requirement that all second trimester abortion procedures be performed in licensed hospital facilities has the effect of totally eliminating or significantly decreasing the availability of second trimester abortions. There can be no greater example of direct state interference infringing on the exercise of a fundamental right than denial of access to the means necessary to effectuate that right. Further, since these requirements drastically limit the availability of the two safest and most common methods of second trimester abortions,[21] the state's asserted interest

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[21] The techniques specifically addressed in these cases are the dilatation and evacuation and saline installation procedures. Recent medical studies demonstrate and courts have

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in protecting the woman's health is revealed to be not a justification, but a transparent excuse.

In view of the demonstrable burden placed on the abortion decision by requiring all second trimester abortions to be performed in hospitals, the state must show that such restriction promotes

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found, that D & E is now the most used and safest procedure for early second trimester abortions, Margaret S. v. Edwards, 486 F. Supp. at 195; Planned Parenthood Ass'n v. Ashcroft, 655 F.2d at 856; Wolfe v. Stumbo, 519 F. Supp. 22, 25 (W.D. Ky. 1980); see Poe v. Dep't of Public Health, No. 78 C 4126 slip. op. (N.D. Ill., May 11, 1981).

Use of the saline method was upheld by this Court in Planned Parenthood v. Danforth, 428 U.S. 52 (1976). In support of its holding, the Court found that saline is "an accepted medical procedure"; if utilized in a "substantial majority . . . of all post-first trimester abortions" it is "safer, with respect to maternal mortality, than even the continuation of the pregnancy until normal childbirth." 428 U.S. at 77, 78. See Colautti v. Franklin, 434 U.S. 379, 398-99 (1979).

its interest in the woman's health. To satisfy this constitutional burden, "the State must show . . . that only the full resources of a licensed hospital, rather than those of some other appropriately licensed institution, satisfy [its] health interests." Doe v. Bolton, 410 U.S. at 195.

The evidence submitted in each case before the Court does not support a conclusion that second trimester hospital abortions are significantly less dangerous to a woman's health than comparable procedures performed in non-hospital clinics. To the contrary, the records below amply demonstrate that the second trimester abortion methods used in these cases -- dilatation and evacua-

tion and saline instillation -- can safely be performed outside a hospital. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d at 1209; Planned Parenthood Association v. Ashcroft, 664 F.2d at 690 (8th Cir. 1981); Simopoulos v. Commonwealth of Virginia, 221 Va. at 1075-76, 277 S.E.2d at 202-03.

It is particularly significant that the American College of Obstetricians and Gynecologists, reversing an earlier position, has concluded that second trimester abortions may be safely performed in non-hospital facilities. See American College of Obstetricians and Gynecologists, Manual of Standards for Obstetrician Gynecological Services at

16 (1982). ACOG has made clear its approval of the performance of abortions on an outpatient basis through the 18th week from the last menstrual period. The American Public Health Association advises that "[r]equirements that all abortions after [the first trimester] be performed in hospitals increase the expense and inconvenience to the woman without contributing to the safety of the procedure." Donovan at 91-92. Similarly, other medical experts have concluded that both procedures can be safely performed in non-hospital facilities. See Cates, Grimes, "Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities," 58 Obstetrics and Gynecology 401

(1981)[22]; Schulman, Kaiser, Randolph, "Outpatient Saline Abortion," 37 Obstetrics and Gynecology 521 (1971).

In view of the medical evidence demonstrating the safety of outpatient second trimester abortions, it is obvious that restrictions which require all second trimester abortions to be performed in hospitals are not reasonably related to the preservation of the woman's health, nor are they narrowly drawn to avoid overbroad interference with a woman's decision whether to bear a child. Planned Parenthood Association v. Ashcroft, 655 F.2d at 853-57; Wolfe v. Stumbo, 519 F. Supp. at 24-25; Marga-

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[22] These authors also suggest that policymakers reconsider laws requiring all second trimester abortions to be performed in hospitals.

ret S. v. Edwards, 488 F. Supp. at 194-96. Thus, there is no medical justification for the restriction.

Moreover, by imposing a hospitalization requirement, the state is deliberately endangering a woman's health. The hospitalization requirement operates to make second trimester abortions unavailable for many women, as discussed at Point I, supra, and adds the burden of time delays for many more. As discussed at Point I, supra, each day of delay increases the woman's health risk. This puts the state's restrictive action in a head-on collision with its acknowledged interest in protecting the woman's health. Far from serving the woman's health interest, the hospitalization

restriction actually endangers the woman's health by effectively "proscrib-[ing] the safest alternative presently available for post-first trimester abortions." Margaret S. v. Edwards, 488 F. Supp. at 193. This result may, "as a practical matter . . . forc[e] a woman and her physician [to continue her pregnancy or] to terminate her pregnancy by methods more dangerous. . . ." Planned Parenthood v. Danforth, 428 U.S. at 79.

Therefore, this restriction is an "unreasonable [or] arbitrary regulation designed to inhibit and having the effect of inhibiting" the vast majority of abortions after the first trimester. Planned Parenthood v. Danforth, 428 U.S. at 79. Accordingly, it is a restriction

that plainly contravenes the constitutionally protected right of women seeking second trimester abortions, and this Court's holdings in Roe v. Wade, Doe v. Bolton and Planned Parenthood v. Danforth.

2. The mandatory consent, attending physician counseling and waiting period restrictions constitute unjustified state interference in the exercise of a fundamental right and are unconstitutional.

a. The challenged restrictions are wholly impermissible when applied in the first trimester of pregnancy.

Roe v. Wade makes clear that there can be no interference with the woman's decision-making process during the first trimester of a pregnancy. 410 U.S. at

163. The challenged consent, attending physician counseling and waiting period restrictions directly interfere with -- indeed disrupt -- the exercise of the constitutionally protected right to abortion. As fully discussed at Point I, supra, these limitations impose substantial burdens on the decision to terminate a pregnancy by abortion. The restrictions add the state as a third party in the decision-making process -- invisible but present, both through words which must be spoken by a state-designated individual and through a forced "cooling off" period. These direct intrusions into the decision to undergo a first trimester abortion are

flatly contrary to the clear mandate of Roe v. Wade, and cannot stand.[23]

b. The challenged restrictions do not advance a compelling state interest when applied after the first trimester of pregnancy.

(1) The consent requirement.

Rather than furthering communication between the physician and patient to enhance understanding of the medical procedure, the mandated consent requirement in the Akron ordinance is a transparent attempt to control the woman's decision whether or not to terminate her pregnancy. It is a far cry from the

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[23] Many lower courts have invalidated similar provisions. See, e.g., Charles v. Carey, 627 F.2d at 784-86; Women's Medical Center of Providence v. Roberts, 530 F. Supp. at 1144; Margaret S. v. Edwards, 488 F. Supp. at 212; Women's Community Health Center v. Cohen, 477 F. Supp. 542, 551-52.

consent requirement upheld by this Court in Planned Parenthood v. Danforth, 428 U.S. 52 (1976). There, the Court scrutinized and upheld a statutory restriction that required a woman, prior to obtaining a first trimester abortion, to certify in writing that her "consent is informed and freely given and is not the result of coercion." Id. at 65. "Informed consent" was construed in Danforth as:

> [T]he giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine an attending physician in an undeserved and uncomfortable straitjacket in the practice of his profession.

428 U.S. at 67 n.8; see Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978),

aff'd, 440 U.S. 941 (1979). The City of Akron has attempted to expand beyond recognition the exception carved out in Danforth -- building from this exception a scheme which would swallow the rule in Roe v. Wade.

The Akron restriction, unlike the provision in Danforth, dictates to the physician precisely what must be said. Apparently, in the City of Akron, being "informed" means a woman is to be told what the government decides she should be told, rather than what her physician believes is necessary to the making of a truly informed decision. Similar restrictive consent directions have been rejected by the courts, finding the language to be an intrusion into the

physician-patient relationship that is not justified by the state's interest in preserving the woman's health.

The importance of a sensitive and individualized approach to the obtaining of consent was aptly described by the U.S. Court of Appeals in Planned Parenthood League v. Belotti:

> [T]he uncontradicted expert testimony . . . indicated that requiring women seeking abortions to read this information ["description of the stage of development of the unborn child"] would cause many of them emotional distress, anxiety, guilt, and in some cases increased physical pain -- and it is of course by its impact on women in that stressful situation, rather than on judges or other detached readers, that the information must be measured.

641 F.2d at 1021.

The likelihood of negative effects on the woman's health from such consent requirements was recognized by both of the lower courts in the Planned Parenthood Association v. Ashcroft litigation. 655 F.2d at 868. As discussed fully at Point I, supra, numerous other courts have examined statutes prescribing the content of the information to be given to a woman seeking an abortion. In none of those cases did the court find a positive relationship between the required information and the woman's health; indeed, courts have tended to find that such information can be damaging to health interests. See, e.g., Leigh v. Olson, 497 F. Supp. at 1345.

These elaborate prescriptions for controlled consent inject the state into the decision-making process by placing the doctor in the "undesired and uncomfortable straitjacket" warned against in Danforth, and are unconstitutional. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. at 1203, aff'd in pertinent part, 651 F.2d at 1207.

(2) The attending physician counseling requirement.

The attending physician counseling restriction prescribes a course of conduct without regard for the physician's professional judgment or the woman's medical needs. It applies to every woman who seeks an abortion, whether or not she has been counseled by her pri-

vate physician prior to referral to a clinic for the specialized services it provides. This state-imposed obligation creates the kind of "straitjacket" found objectionable by this Court in Danforth, and is impermissble under Roe. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. at 1203, aff'd in pertinent part, 651 F.2d at 1207.

The attending physician requirement is not only burdensome, but inimical even to meet the asserted need: protection of the woman's health. Charles v. Carey, 627 F.2d at 784. Thus, strict scrutiny reveals no compelling state interest to justify this restriction.

(3) The mandatory waiting period requirement.

Similarly, statutes which fix inflexible requirements that abortions be postponed do not advance the state's interest in preserving the woman's health, and are thus unconstitutional. As discussed at Point I, supra, a state-mandated delay in the performance of an abortion deprives a woman of the right to end her pregnancy after she has voluntarily and knowingly decided to do so. This delay often, as noted at Point I, supra, results in postponing the abortion for a substantially longer period of time, since many facilities provide abortion services only once or twice a week. Such a delay can increase the risk to the woman's health. The fact

that imposition of a waiting period exacerbates, rather than ameliorates, the potential health risks has led the lower courts to invalidate such requirements. See, e.g., Planned Parenthood Association v. Ashcroft, 655 F.2d at 866 (48-hour waiting period),[24] Planned Parenthood League v. Bellotti, 641 F.2d at 1014 (24-hour waiting period); Charles v. Carey, 627 F.2d at 785 (24-hour waiting period); Margaret S. v. Edwards, 488 F.Supp. at 212 (24-hour waiting period); Women's Services, P.C. v. Thone, 483 F.Supp. 1022, 1050 (D. Neb. 1979), aff'd, 636 F.2d 206 (8th Cir. 1980), vacated and remanded on other grounds, 452 U.S. 911 (1981) (48-

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[24] The state has not sought review of this holding.

hour waiting period). This requirement reflects government attempts to coerce a woman to carry her pregnancy to term, irrespective of her physical and psychological condition; it fails to meet the strict scrutiny test.

CONCLUSION

For the foregoing reasons, the legislative provisions requiring that post-first trimester abortions be performed in hospitals, that physicians be required to convey specified information prior to obtaining a patient's consent for an abortion, that only the attending physician may counsel a patient at the stage of obtaining her consent, and that a woman must endure a mandatory waiting period after she has given her consent,

should be declared unconstitutional.

Respectfully submitted,

Phyllis N. Segal
Judith I. Avner
(Counsel of Record)
Anne E. Simon

NOW Legal Defense and
Education Fund
132 West 43rd Street
New York, N.Y. 10036

Jemera Rone
919 Third Avenue
New York, N.Y. 10022

Attorneys for Amici Curiae[25]

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[25] Attorneys for amici gratefully acknowledge the assistance in the preparation of this brief provided by Elise Berkower, Rebecca Arce, Naomi Cahn, Constance Buttner, William Lashner, Suzanne Senay, Susan Wells, Timm Whitney.

Amicus Brief

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IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1982

Nos. 81-185
CHRIS SIMOPOULOS, M.D., FACOG

vs.

COMMONWEALTH OF VIRGINIA

ON APPEAL FROM THE SUPREME
COURT OF VIRGINIA

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE WITH ANNEXED BRIEF OF WOMEN LAWYERS OF SACRAMENTO, PLACER COUNTY WOMEN LAWYERS, AND AUBURN WOMEN'S CENTER

Nancy Reardan
2018 19th Street
Sacramento, California 95818
(916) 441-0720

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Amici respectfully move this Court for leave to file the attached brief.

Amici are associations of women and men lawyers who seek the elimination of sex discrimination through the legal profession.

The annexed brief argues that the Commonwealth of Virginia violates federal provisions requiring equal protections for all citizens by placing onerous and medically unjustified burdens upon women, thereby unduly restricting their access to pregnancy terminations.

Amici also contend that Virginia has created a double standard, and un unnecessary classification scheme based on gender. Virginia has failed to justify this scheme by any substantially related, important state interest.

We have sought the consent of the parties to file this brief amici curiae. Counsel for Dr. Chris Simopoulos has consented. Counsel for the Commonwealth of Virginia declined to consent.

Respectfully submitted,

Nancy Reardan
2018 19th Street
Sacramento, Ca., 95818

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Harris v. McRae
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STATUTES

Utah Code Ann. §76-7-304

U.S. Constitution, Amendment XIV

OTHER AUTHORITIES

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California Department of Consumer Affairs, *Pregnant Women and Newborn Infants: A Deepening in Health Care* (1982).....15

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Pearce, Diana "The Feminization of Poverty" *Urban and Social Change Review* (Feb 1978).....19

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AMICI CURIAE BRIEF OF WOMEN LAWYERS OF SACRAMENTO, PLACER COUNTY WOMEN LAWYERS, AND AUBURN WOMEN'S CENTER

This brief is submitted by the undersigned amici curiae conditionally upon the granting of the motion for leave to file, to which it is attached.

INTEREST OF AMICI CURIAE AND CONSENT

The named county women lawyers associations are membership organizations consisting of women and men who seek elimination of sex discrimination through the legal profession. Members represent clients in California who have suffered gender discrimination in violation of federal protection under the Fourteenth Amendment of the U.S. Constitution.

Amici are concerned that the federal provisions which assure equal protection for all citizens are being unduly restricted by laws which create a double standard by requiring parental consent for termination of a pregnancy for minor women, and not for minor men, and which impose medically unnecessary burdens on women.

INTRODUCTION

This case asks difficult questions about the extent to which a government may impose burdens, in the guise of "protections", on women because they are women. This brief posits that the asserted justifications for the restrictions at issue are a sham, and that the additional and unusual burdens imposed by Virginia on a woman's right to terminate her pregnancy are unsupportable under the U.S. Constitution as previously interpreted by this Court.

The authors of this brief acknowledge to the Court and to the world that women are biologically different from men. We acknowledge that only women can become pregnant. A fortiori, we believe, only

the woman can decide to terminate her pregnancy.

This Court has recognized this principle, characterizing the decision to terminate a pregnancy as one that is personal to a woman and her physician. The Court has instructed the nation that privacy in the exercise of that decision is constitutionally required.

This brief questions the extent to which a state may heap unusual medical, financial, familial and social requirements on the exercise of this particular medical decision. Amici ask the Court to consider whether laws imposing these burdens should be permitted to escape strict scrutiny under the Equal Protection Clause of the United States Constitution for no other reason than that the basic burden, the pregnancy, can fall upon women alone.

This Court has repeatedly held that the fundamental right to privacy in matters involving contraception, marriage and the right to procreate shall not be infringed. Harris v. McRae 448 U.S. 297 (1980); Roe v. Wade 410 U.S. 113 (1973); Eisenstadt v. Baird 405 U.S. 438 (1972); Griswold v. Connecticut 381 U.S. 479 (1965).

The instant statute allows the state to infringe on this fundamental right by placing unnecessary burdens on the procreative choice of females only. Women, but not men, must (1) if they are minors, obtain their parents' consent for a pregnancy termination and (2) incur the expense of hospitalization for second trimester abortions. Amici address in this brief these most pernicious requirements: mandatory parental approval for

minor females and mandatory hospitalization.

Amici respectfully request the Court's recognition of the fact that pregnancy in itself is an unusual physical, personal and financial burden, and that the burden falls hardest on unmarried, poor, minor women. Amici ask the Court to imagine the stress of nine months of unwanted pregnancy and to be mindful of the life prospects for unwanted children. Amici ask the Court to hold unconstitutional the burdening of women with a duties imposed on no others under the law. Amici respectfully urge this Court to strike down laws which individually and collectively impinge upon a woman's right to terminate her pregnancy and which have, until now, avoided scrutiny because the suffering falls only on one sex.

ARGUMENT

I

THE VIRGINIA STATUTES CREATE A DOUBLE STANDARD.

A. Sexually Active Men And Women Under Age 18 Are Treated Differently.

Gender-based classifications may not be based on archaic assumptions about the proper role of the sexes. Reed v. Reed 404 U.S. 71 (1971); Frontiero v. Richardson 411 U.S. 677 (1973); Craig v. Boren 429 U.S. 190 (1976); Califano v. Wescott 443 U.S. 76 (1979); Wengler v. Druggist Mutual Insurance Co. 446 U.S. 142 (1980); and Mississippi University for Women v. Hogan ___ U.S. ____, 50 USLW 5068, 5070 (July 1, 1982,).

In Virginia, young women who become pregnant are burdened by regulations which require parental approval of a decision to terminate a pregnancy. Young men, though equally responsible and interested in the pregnancy, are subject to no similar regulation, whether or not they are emancipated.

By omitting young men from the purview of this statute, Virginia implies that young men are sufficiently mature to regulate their procreative activity and therefore not in need of parental guidance or supportive conversation. The parents of sexually active young men under 18 may never know of their sons' responsibility for resultant pregnancies. These provisions allow young men to abrogate their responsibilities and serve only to perpetuate the double standard

which permits men to be sexually active but requires that women be chaste or suffer the consequences.

B. The Parental Approval Requirement Stigmatizes and Punishes Minor Women

The psychological burden of an unwanted pregnancy effectively stigmatizes young women.

Kenneth Karst in "Equal Citizenship Under the Fourteenth Amendment" 91 Harvard Law Review 1, 57 (1977) states that women will achieve equal citizenship only when the judiciary rejects the symbolism of dependency. However, Karst points out this will not occur as long as:

> (1) our society's traditional double standard of sexual morality . . . places a greater stigma on unmarried women who become pregnant, than on

> the men who father their children; (2) our society's continuing expectation is that women take the major responsibility for contraception and childcare. Id., 37.

As long as the state of Virginia continues to place burdens solely on women, it supports this double standard for men and women and stigmatizes women.

Karst points out that when one person is singled out for treatment which places her in a dependent status, e.g. by requiring a young woman seeking a pregnancy termination to notify her parents and obtain their consent, her identity is damaged. Enforced dependency results in second-class status. The young woman becomes a victim who "suppresses aspirations that look unattainable when seen with the restricted vision imposed by a withered self-concept." Id., 7.

As long as women must suffer medically unnecessary, legislatively-imposed restrictions, but men need not, women are stigmatized, and men escape unscathed for the same conduct. Such restrictions "reflect archaic and stereotypic notions". Mississippi University for Women v. Hogan, supra, 50 U.S.L.W., 5070.

It is established that "the absolute nature of the statutory requirement. . . violates the requirement that regulation in this fundamentally personal area be carefully tailored to serve significant state interests." H.L. v. Matheson, supra, 450 U.S. 446. However, given the social stigma and medical dangers involved in childbirth for minor women, to preclude termination of an unwanted pregnancy because of statutorily imposed parental intervention not only fails to

serve such an interest, but also serves only to punish pregnant minors. Men, no matter what age, are not subject to similar parental intervention.

II

BECAUSE AN UNWANTED PREGNANCY PER SE CONSTITUTES A BURDEN ON A WOMAN, MEDICALLY UNNECESSARY RESTRICTIONS ON PREGNANCY TERMINATIONS VIOLATE EQUAL PROTECTION.

A. Pregnancy Itself Constitutes A Burden On Women

1. Physical Burden

Donald H. Regan, "Rewriting Roe v. Wade" 77 Michigan Law Review 1569 (1979), fills four pages with the ordinary complaints which accompany any pregnancy. From faintness and nausea to the risk of death in childbirth, virtually all women must "...put up with enough pain, discom-

fort and disruption of appearance and emotional state to add up to a major burden."

Regan further states, "It is worth mentioning that all of the pains and discomforts listed above are likely to be aggravated when the entire pregnancy is unwanted. It is much easier to bear up under pain and inconvenience when they serve some end one has chosen than when they do not...." Id., 1582.

Regan discusses the equal protection aspects of pregnancy termination through the use of a "good samaritan" tort analysis. Id., 1636. No person has a duty to come to the assistance of any other person except in the abortion context, where a woman is required to sacrifice herself for a fetus. The state's interest in potential life can never justify forcing

a woman to risk her health for another life. Id., 1640. No woman should be forced by any other person or the state to bear children. This is symptomatic of a totalitarian society that does not support "constitutional values [such as] non-subordination, freedom from physical invasion, and equal protection." Id., 1639.

2. Lack Of Adequate Medical Care

In addition to the personal physical burden of pregnancy, women experience difficulty in obtaining medical care. In many parts of the country, family planning and prenatal services are virtually nonexistent. In March 1982, the State of California reported that basic obstetric and gynecologic services from high quali-

ty fee-for-service physicians and private hospitals are unavailable to all but the most affluent. California Department of Consumer Affairs, Pregnant Women and Newborn Infants: A Deepening Crisis in Health Care.

The consequences of inadequate access are seen most graphically in comparisons of infant mortality rates. For example, the infant mortality rate in Scandinavian countries is six per one thousand.*

In California, the infant mortality rate is 12.3 per one thousand for white infants. This rate doubles in medically underserved areas: for example, for

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*This rate correlates with national health insurance programs which provide coverage for all pregnancies and all pregnancy terminations, plus universal access to contraceptives, irrespective of age.

Black infants in Oakland, the rate is 23.6 per 1,000; for Hispanic infants at L.A. County Medical Center, 25 per 1,000; and for infants born in rural El Dorado County, 23 per 1,000. Lower rates of infant mortality correspond to prenatal care during the first trimester. Dallek, Geraldine, "Maternal Health Care in America: Sliding Back Down the Mountain," National Health Law Project, 1981,5.

This lack of adequate care constitutes a burden on pregnancy over which pregnant women have no control. It is another burden in the area of procreative freedom which affects only women.

3. Parenthood And Poverty

Financial barriers compound the demographic/geographic lack of access to medical care.

The Supreme Court in Harris v. McRae 448 U.S. 297 (1980) held that the federal government may choose to fund childbirth and not pregnancy termination. Since then, governmental financial policies have effectively denied access to health care during pregnancy for significant numbers of women.

Even childbirth in hospitals is precluded for financial reasons. Hospital imposed financial restrictions often include requiring deposits or Medicaid co-payments, and requiring on-staff referring doctors for admission or doctors who will accept Medicaid patients.

Dallek's study, "Maternal Health Care" etc., supra found that financial constraints alone, without additional restrictions, resulted in more than fifty percent of all children in Brownsville,

Texas being born outside hospitals. Dallek also documents that nineteen states do not cover first-time pregnant women under their Medicaid programs.

In many states it is not unusual for all but state- or county-funded hospitals to reject women in labor. These institutions often go bankrupt because indigent care drains the financial resources of the state or local government. In California, between 1970 and 1980, 24 out of 57 county hospitals were closed for this reason.

Thus, the irony of governmental refusal to pay for pregnancy termination compounds the ignominy of its refusal to pay for childbirth and prenatal care in a hospital or clinic.

The National Advisory Committee on Economic Opportunity in "The American

Promise: Equal Justice and Economic Opportunity," (1981) concluded that over fifty percent (217,000) of all poor families are headed by women.

In a seminal article "The Feminization of Poverty: Women, Work and Welfare," Urban and Social Change Review (February, 1978), Diana Pearce outlines the shift of poverty from two-parent households to women-headed households in the 1980's. More than forty-six percent of these women were never married and a majority of them did not see a doctor at all until the second trimester of pregnancy.

This Court noted the link between poverty and teenage pregnancy in Michael M. v. Sonoma 450 U.S. 470 fn.3 and 4, citing the Alan Guttmacher Institute's 11 Million Teenagers, at 10, 13, 23, 25.

Frequently undereducated because they left school as a result of unwanted pregnancies, these women barely subsist on Aid For Dependent Children (AFDC) programs.*

The physical, financial and personal burdens of pregnancy are magnified when the pregnancy is unwanted, or when it befalls a minor, unmarried woman. Even in the absence of any statutory restrictions, an unwed woman seeking a pregnancy termination must overcome severe hurdles. Initially, she must find a doctor who will see her to determine whether she is

*These programs range from $26.00 per person per month in Mississippi to $119.00 per person per month in New York. The average for the nation is $5,318.00 for families on welfare compared with the $21,703.00 national median income of two-parent working families.

pregnant. In rural areas of the U.S. and in medically underserved urban areas, it may be difficult to locate a local doctor. A woman frequently must travel to a distant community that provides obstetric and gynecological care. She is therefore faced with transportation and lodging expenses. If an individual is indigent, the number of doctors taking Medicaid is severely restricted because these rates are below private rates. All of these factors serve only to delay, thereby increasing the duration of the procedure, the cost of medical treatment, the psychological damage, and the chance of maternal death.

III

VIRGINIA HAS FAILED TO DEMONSTRATE THAT PARENTAL APPROVAL FURTHERS ANY IMPORTANT

STATE INTEREST SUBSTANTIALLY RELATED TO THE GENDER CLASSIFICATION

Among the interests proffered by the State in justification of the gender classification inherent in the approval requirement are the protection of maternal health and the promotion of family integrity. These interests are spurious.

A. The Parental Approval Requirement Fails To Advance the State's Interest in Promoting Maternal Health.

State policies that discriminate on the basis of gender must show that the classification serves "important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." Wengler v. Druggists Mutual

Insurance Co., 446 U.S. 142, 150. The classification must assist "members of the sex that is disproportionately burdened." Mississippi University for Women v. Hogan, 50 U.S.L.W. 5069.

Parental approval in Virginia is an absolute barrier to pregnancy terminations performed in hospitals, because all hospitals statutorily require this approval.

Virginia has failed to make any showing that a substantial state interest in maternal health is furthered by the parental approval requirement. The state implies that only parental consent can foster maternal health indirectly by promoting parental guidance on the topic of pregnancy. Allegedly, the subject statute, like the Utah statute in H.L. v. Matheson, supra 450 U.S. 424, "would tend

to facilitate communication between daughters and parents."

However, the Court in H.L. failed to mention the parental communication which might prove helpful between the male, who must share the responsibility for the pregnancy, and his parents. This type of statute thus assumes that female minors are unable to make decisions regarding contraception and pregnancy, while male minors are able to so decide. This distinction is unjustified by any showing made by Virginia, especially in light of the generally-accepted premise that females mature earlier than males.

The parental approval requirement creates a presumption that all minor women are immature, whereas minor males are presumed sufficiently mature to make medical decisions. During the second

trimester of gestation, each day of delay, pending parental approval, pushes the pregnant woman into greater medical danger. The stated purpose of protecting maternal health certainly is not achieved under this exception.

If parental consent requirement does, in fact, support a substantial interest in communication between parents and children concerning pregnancy, then parents of minor males must also logically be notified.

B. Parental Consent Requirements Do Not Serve the State Interest in Protecting Family Integrity.

News reports daily confirm that young women are subject to sexual assault by fathers, step-fathers other male rela-

tives and boyfriends (See, e.g., Sacramento Bee, July 14, 1982; See also Planned Parenthood Association of Kansas City v. Ashcroft, 655 F.2d 848,859, fn. 13 (1981), where data is cited showing that 50% of children age 12 and younger who seek abortions are incest victims.) Others are victims of child abuse, parental alcoholism and drug abuse, mentally ill parents, and the stresses accompanying divorce. Forced communication between pregnant minor females and parents who endanger these children can hardly be deemed to promote family integrity.

According to Justice Marshall, dissenting in H.L. v. Matheson, supra 450 U.S. 448, the purpose of cases protecting parental authority is to protect the family from state intrusion, not to jus-

tify mandatory state intrusions. "Whatever its motive, state intervention is hardly likely to resurrect parental authority that the parents themselves are unable to preserve."

IV

THE STATUTE MANDATING HOSPITALIZATION FOR PREGNANCY TERMINATIONS CREATES AN UNNECESSARY CLASSIFICATION SCHEME BASED ON GENDER.

A. Virginia's Statutory Hospitalization Requirements Apply Only To Pregnancy Terminations And Not To All Surgeries With Similar Risks.

Although states protect the health and well-being of their citizens by requiring physicians to be examined and licensed by the State and by requiring

hospitals and clinics to meet various building and inspection standards for licensure, states do not generally substitute legislative dictates for a physician's judgment on how best to medically treat a specific patient. See Doe v. Bolton, 410 U.S. 179, 199 (1973). Rather, the emphasis in our society has been precisely opposite, that is, to encourage and respect the physician's judgment and expertise in medical areas. As this Court has previously stated,

> "...medical judgment may be exercised in the light of all factors [such as] physical, emotional, psychological, familial, and the woman's age - relevant to the well-being of the patient.... This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the [patient]." Id., 192.

Yet, Virginia has inserted its legislative judgment in place of the doctor's

best medical judgment concerning the health of the patient. No other surgical or medical procedures are so burdened. Thus, a doctor may assess, free from the chill of statutory prohibitions, all relevant factors pertaining to the health of the individual patient when determining whether to perform a vasectomy, a commonly used male sterilization procedure, in a medical office, a clinic or a hospital. If a doctor does not exercise adequate medical judgment and a patient is injured because a procedure is improperly performed on an out-patient basis, then the doctor will be subject to civil liabilities, Doe v. Bolton, 410 U.S. at 199.

Under the Virginia law, however, if a doctor weighs all the factors relating to the health of his patient and, in the

exercise of sound medical judgment, elects to perform a pregnancy termination in an office or clinic, that election will have violated the legislative proscription. To isolate pregnancy terminations in this way "treats differently, without a compelling reason, medical procedures which in terms of health risk are not distinguishable." Friendship Medical Center v. Chicago Board of Health, 505 F.2d 1141, 1153 (7th Cir.) cert. denied 420 U.S. 997 (1974). Such differential treatment violates the Equal Protection Clause of the Fourteenth Amendment. See Doe v. Bolton, supra, 410 U.S. 194; Planned Parenthood of Virginia v. Danforth, 428 U.S. 52, 77-78 (1976); Bellotti v. Baird, 428 U.S. 128, 149-150 (1976).

The statute challenged here indirectly regulates the conduct of women seeking second trimester abortions by imposing criminal sanctions on their doctors. This Court has consistently recognized that restricting the operations of providers of goods or services may "result indirectly in the violation of third parties' rights." Warth v. Seldin, 422 U.S. 490, 510 (1975); Carey v. Population Services International, 431 U.S. 684, 694 (1977); Craig v. Boren, 429 U.S. 190, 195 (1976).

In the instant case a female patient seeking an abortion was denied "the right to receive medical care in accordance with her licensed physician's best judgment" and the physician was denied "... the right to administer it." Doe v. Bolton, 410 U.S. at 197.

There is no similar context in which a class of male patients has been denied the medical care which a physician deems best for the particular patient. Such differential treatment establishes a statutory classification that distinguishes between males and females solely on the basis of gender.

B. Criminal Sanctions Against Performing Pregnancy Terminations In Non-Hospital Facilities Result In Invidious Discrimination.

This Court has repeatedly held that "gender-based discriminations must serve important governmental objectives and that the discriminatory means employed must be substantially related to the

achievement of these objectives." Wengler v. Druggists Mutual Insurance Co., supra, 446 U.S. 142, 150

The alleged state interest in the hospitalization requirement at issue is maternal health. Virginia has the burden of showing a direct and substantial relationship between the hospital requirement and the objective of protecting maternal health. Mississippi University for Women v. Hogan, ___ U.S. ___, 50 U.S.L.W. 5068, 5070. Virginia has failed to satisfy this burden.

There is no evidence in this case that licensed physicians in Virginia are incapable of making reasoned decisions when selecting medical settings for the performance of minor surgery. Yet the state, to rationalize its statute, must believe that doctors are competent to

select proper settings for all types of surgery except pregnancy terminations.

Virginia has failed to establish that licensed physicians are incompetent in caring for these patients. This Court is respectfully requested to find that licensed physicians exercise the same degree of care in determining which patients to hospitalize irrespective of the medical condition of the patient.

The necessary inference derived from the statute, that physicians who perform pregnancy terminations are criminals is a mechanical application of an inaccurate stereotype about the need of women for special protection. Further, such a legislative judgment has been held improper. Mississippi University of Women v. Hogan, supra ___ U.S. ___, 50 U.S.L.W. 5070. In the era of back-alley and

kitchen-table abortions and less sophisticated medical procedures, a legislative body may have had a legitimate basis for regulating the setting for pregnancy terminations. Such is far from the case in the 1980's. All the medical practitioners performing pregnancy terminations subject to the hospital requirements at issue herein are licensed physicians.

Virginia has failed to establish that non-hospital settings are inherently unsafe. A common pregnancy termination technique, dilatation and evacuation (D & E) is safely performed in out-patient clinics through the 17th and 18th weeks of pregnancy, well into the second trimester. Since the Roe decision in 1973, specialized clinics for the performance of legal pregnancy terminations have had nearly 10 years to train and develop staff with expertise in these procedures.

In the modern factual setting, licensed physicians must be free to exercise their professional judgment in selecting appropriate settings for all medical procedures without legislative interference. To decide otherwise is to unwisely hold onto the shibboleths of the past. The State's hospitalization requirements merely reinforce the traditional sexual stereotype that women need special protection from their own doctors. These medical myths have led to gender-based classifications and legislative decisions which are unconstitutional as well as unwise. This Court has recognized that in the areas of medicine and pregnancy termination rights, states should readjust their "views and emphases in the light of the advanced knowledge and techniques of the day." Doe v. Bolton, 410 U.S. 179, 190-191 (1973).

Virginia has failed to demonstrate that pregnancy termination complications are not as safely treated by a licensed physician in a non-hospital medical facility as in a hospital. Serious complications during and after a pregnancy termination are rare and can occur in any setting, including a hospital. Mahoning Women's Center v. Hunter, 444 F.Supp. 12, 15 fn 7 (N.D. Ohio 1977). Virginia has not met its burden of showing that a licensed physician exercises criminal judgment by treating those rare complications in a licensed clinic rather than in a hospital. Moreover, many doctors believe there is an increased risk of complications when pregnancy terminations are performed in hospitals instead of in out-patient clinics. Because of exposure to a larger patient population, some

of whom are suffering from communicable diseases, there is an inherently greater risk of infection in a hospital than in a smaller clinic.

No similar prohibitions are imposed on licensed physicians attending home births, at which the risk to maternal health is as great as or greater than that borne by a woman undergoing an pregnancy termination at a well-equipped, licensed medical clinic. Similarly, there is no proscription against the performance of amniocentesis by licensed physicians in clinics. If the risk to maternal health were in fact the real basis for the mandatory hospitalization requirement, the same requirement would logically be extended to childbirth and amniocentesis.

In reality, Virginia cannot show that its hospital requirement is substantially related to the protection of maternal health.

Ironically, the mandatory hospitalization requirement, which many women cannot afford, may in fact be forcing women to return to back-alley, non-physician pregnancy terminations.

Virginia has further failed to establish that a gender-neutral scheme is a less effective means of achieving its important governmental objective. Wengler v. Druggist Mutual Insurance Co., supra, 446 U.S. 151, and Orr v. Orr, supra, 440 U.S. 282.

Virginia has a gender-neutral mechanism for the protection of maternal health without the need for extraordinary prohibitions imposed upon doctors and

patients. Virginia licenses all physicians, and regulates and licenses all medical facilities, including clinics. Aggrieved and injured patients have access to the courts of Virginia to file claims against physicians and clinics for negligence and other malpractice. All of these protections exist without reference to gender. Therefore, the state's imposition of the hospitalization requirement ineffectually attempts to protect interests in maternal health, interests already adequately protected. These extra layers of state intervention directly hamper the ability of doctors to practice medicine. See Word v. Poelker, 495 F.2d 1349, 1351 (8th Cir. 1974).

Virginia has been unable to demonstrate that it requires physicians who perform minor surgery with risks equal to

those in pregnancy termination cases to operate only in hospitals. "[T]hat the state is ordinarily willing to leave such matters to the professional judgment of the attending physician strongly suggests that the program for regulating abortion clinics is a thinly disguised effort to evade Roe and Doe." Friendship Medical Center, Ltd, v. Chicago Board of Health, 505 F.2d 1141, 1153 fn. 17 (7th Cir. 1974), cert. denied, 420 U.S. 997 (1975).

Once this Court abandons the traditional notion that female patients require special legislative protection from licensed physicians who perform pregnancy terminations, there is no basis for finding a substantial relationship between the hospitalization requirement and the governmental objective. Cf. Mississippi University for Women v. Hogan, supra, at 5070 fn.11.

CONCLUSION

Under the guise of protections, legislatures have denied women access to professions, schools, and now adequate medical care. No man is subjected to such unreasonable and unsubstantiated nonmedical barriers to medical care. The state chooses not to interfere because it recognizes the necessity of speedy treatment and respects the doctor/patient relationship.

Not so with women. Here the State presumes to establish nonmedical preconditions for treatment. These conditions are unrelated to treatment. Each day a pregnancy termination is delayed because of parental consent, hospitalization or any other nonmedical legislative order, the risks to the woman's life and health

increase. Hence, even if a state has a vested interest in maternal health in the second trimester, this interest is not served by delaying and complicating pregnancy teminations. Denying access to medical care to women but not to men through impermissible nonmedical barriers constitutes a denial of equal protection.

Respectfully submitted,

JUDITH A. HARPER
Women Lawyers of Sacramento
P.O. Box 161523
Sacramento, CA 95816

TAMARA DAHN
Placer County Women Lawyers
c/o Legal Services of
Northern California
199 Hoffman Avenue
Auburn, CA 95603

NANCI CLINCH
102 Colfax East
Grass Velley, CA 95945

MARGARET M. HALLORAN
Women Lawyers of Sacramento
1365 Oak Nob Way
Sacramento, CA 95833

ESTELLE A. SCHLEICHER
Women Lawyers of Sacramento
1005 Eighth Street, Ste 406
Sacramento, CA 95814

Docket Sheet

NO. 81-185-ASY	TITLE Chris Simopoulos, Appellant, v. Virginia

DOCKETED	COURT
July 30, 1981	Supreme Court of Virginia

DATE	PROCEEDINGS AND ORDERS
	Counsel for appellant: Roy Lucas
	Counsel for appellee: Thomas D. Bagwell,
July 30, 1981	Statement as to jurisdiction filed. (Record filed).
Sept. 16, 1981	DISTRIBUTED. 10/9/81.
Oct. 2, 1981	Response Requested.
Nov. 2, 1981	Motion to dismiss or affirm filed.
Nov. 4, 1981	DISTRIBUTED. 11-25.
Dec. 1, 1981	REDISTRIBUTED. 12-4.
Jan. 18, 1982	REDISTRIBUTED. 1-22.
Feb. 8, 1982	REDISTRIBUTED. 2-19. (Stricken)
Mar. 31, 1982	REDISTRIBUTED. 4-16.
Apr. 20, 1982	REDISTRIBUTED. 4-23. (Stricken)
Apr. 27, 1982	REDISTRIBUTED. 4-30. (Stricken)
May 10, 1982	REDISTRIBUTED. 5-13.
May 17, 1982	REDISTRIBUTED. 5-20.
May 24, 1982	Probable jurisdiction NOTED.

June 16, 1982	Order extending time to file the joint appendix and appellant's brief on the merits until Aug. 6, 1982.
June 19, 1982	Motion of Alan Ernest to represent children unborn and born alive filed.
June 19, 1982	Motion of Legal Defense Fund for Unborn Children for leave to file a brief as amicus curiae filed.
June 28, 1982	The motion of Legal Defense Fund for Unborn Children for leave to file a brief as amicus curiae is GRANTED. The motion of Alan Ernest to represent children unborn and born alive are DENIED.
Aug. 4, 1982	Motion of Committee for Abortion Rights and Against Sterilization Abuse, et al. for leave to file a brief as amici curiae filed.
Aug. 4, 1982	Motion of National Organization for Women, et al. for leave to file a brief as amici curiae filed.
Aug. 4, 1982	Motion of Certain Law Professors for leave to file a brief as amici curiae filed.
Aug. 6, 1982	Motion of Women Lawyers of Sacramento, et al. for leave to file a brief as amici curiae filed.
Aug. 6, 1982	Brief for the appellant filed.
Aug. 9, 1982	Joint appendix filed.
Aug. 7, 1982	Motion of American Public Health Association for leave to file a brief as amicus curiae filed.

(Over)

81-185

Title

No.

DATE	PROCEEDINGS AND ORDERS
Sept. 9, 1982	Brief for the appellee filed.
Sept. 9, 1982	The motion of National Organization for Women, et al. for leave to file a brief as amici curiae is GRANTED. The motion of Committee for Abortion Rights and Against Sterilization Abuse, et al. for leave to file a brief as amici curiae is GRANTED. The motion of Certain Law Professors for leave to file a brief as amici curiae is GRANTED.
Sept. 10, 1982	Brief, amicus curiae, of Americans United for Life in Support of Appellee filed.
Sept. 20, 1982	Motion of The Legal Defense Fund for Unborn Children for leave to participate in oral argument as amicus curiae filed.
Oct. 4, 1982	The motion of American Public Health Association for leave to file a brief as amicus curiae is GRANTED. The motion of Women Lawyers of Sacramento, et al. for leave to file a brief as amici curiae is GRANTED. The motion of The Legal Defense Fund for Unborn Children for leave to participate in oral argument as amicus curiae is DENIED.
Nov. 23, 1982	Reply brief for the appellant filed. (D).
Nov. 30, 1982	ARGUED.